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CHAPTER TEN

Adolescent Substance Abuse: Multidimensional Family Therapy in Action

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Drugs are news. In contemporary America, perhaps as never before, a preoccupation about drug use and abuse pervades our culture. This is appropriate since the United States has the highest rate of adolescent drug use among the world's industrialized nations (Falco, 1988). The range and diversity of drug abuse and drug-related problems of adolescents, the number of teenagers in need of treatment or care, and the costs to society are enormous (see Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990; Institute of Medicine Report, 1989). Public opinion polls

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proclaim the drug problem to be our country's greatest social dilemma, and once again our nation's president has declared a "war on drugs." Frequently, this battle is waged primarily in the domain of law enforcement. The drug-related stories that appear on the evening news highlight videotapes authenticating seizures of large illegal drug shipments. Our society still fumbles to formulate effective policies that will address the "national tragedy" (Daruna, 1990) of adolescent drug abuse. We remain in an era that seeks simplistic answers to the etiology (e.g., peer influence) and treatment (e.g., "Just Say No") of complex, multilevel problems. As Nadelman (1989) warns, a narrowly conceived national policy that continues to overemphasize strategies such as curtailing supply and discouraging use by fear-inducing tactics is likely to be counterproductive.

Less visible, sensational, and funded are treatment efforts, especially those targeted at adolescents. Often characterized as "just experimental users," teenagers who abuse drugs and alcohol typically cannot command research and treatment support. Failing to develop and evaluate drug treatment programs for adolescent users yields serious consequences to both the adolescent and society (Coombs, 1988; Dryfoos, 1990). Newcomb and Bentler (1988), for example, have documented the long-term negative consequences of adolescent drug abuse on mental health, social connectedness, dating and marriage patterns, work stability, and educational aspirations.

Systematic studies on adolescent drug-abuse treatment has not only been sorely neglected but those few psychotherapy outcome studies of adolescent problems (Kazdin, Bass, Ayers, & Rodgers, 1990) have yielded distressing conclusions for those who wish to take therapeutic outcome seriously. Meta-analyses reveal that good therapeutic outcome with teenagers is a very difficult proposition (Casey & Berman, 1985; Tramontana, 1980; Weisz, Weiss, Alicke, & Klotz, 1987). Moreover, Weisz and colleagues (1987) found that problems of undercontrol (e.g., aggression, impulsivity) were less successfully treated than problems of overcontrol (e.g., shyness). Given conclusions of this nature, and since drug abuse can best be considered a problem of "undercontrol," it is reasonable to conclude that constructing and testing effective treatment programs for adolescent drug abusers presents a formidable challenge for those who attempt treatment and research in this area.

In the mid-1980s, the National Institute on Drug Abuse (NIDA) launched an initiative to address the possibilities of constructing family therapy models to treat adolescent drug abuse. Since a successful family therapy approach for drug abuse had been empirically established by teams led by clinical researchers such as Stanton (Stanton & Todd, 1982) and Szapocznik (Szapocznik, Kurtines, Santisteban, & Rio, 1990), as well as others (see review by Bry, 1983), NIDA was interested in whether effective family therapy treatment models could be developed with adolescents (*Con-*

gressional Record—Senate, 1990; National Institute on Drug Abuse, 1983).[1]

This chapter presents aspects of a family therapy treatment model developed in a NIDA-funded study—the Adolescents and Families Project.[2] Rather than presenting the entire approach, our aim here is to offer certain key units of the family therapy treatment manual that directed our clinical work.[3]

Multidimensional Family Therapy

Multidimensional family therapy (MDFT) is a multisystemic treatment approach for adolescent substance abuse and its correlated behavior problems (Liddle, 1991a, 1991b). With its roots in the integrative structural-strategic family therapy tradition (Fraser, 1982; Stanton, 1981; Todd, 1986), MDFT incorporates additional notions about the targets, mechanisms, and methods of change. It is a reformulation of the structural-strategic family therapy of Liddle (1984, 1985).[4] The model's refinement was driven by the mandate of our research project: to construct a specialized treatment model for adolescent substance abuse. This activity, the refinement of an existing integrative approach, was influenced by the contemporary general spirit in drug-abuse treatment (Liddle & Schmidt, 1991; National Institute on Drug Abuse, 1991) and psychotherapy (Miller & Prinz, 1991) of *treatment development* (i.e., greater particularization of treatment models, population-specific treatment manuals, theory-specific outcome, therapy process specification) and *model enhancement* (i.e., the reconstruction of treatment packages for specific purposes).

Conceptually, MDFT reflects a trend in the literature to conceive of adolescent problems such as drug use and delinquency as correlated behaviors. Current thinking in this area is captured in Dishion, Reid, and Patterson's (1989) argument for understanding drug abuse and delinquency as "somewhat different aspects of a unified behavioral process" (p. 189). This perspective typifies the current thinking and research in this area. An extensive literature review concluded a strong relationship of adolescent substance abuse to conduct disorder (Bukstein, Brent, & Kaminer, 1989). There is a growing consensus among investigators and clinicians on the importance of understanding adolescent problems in a multivariate, multisystemic, nonreductionistic fashion (Loeber, 1985; Elliot, Huizinga & Ageton, 1985; Fishman, 1986; Henggeler, Rodick, Bourdin, Hanson, Watson, & Urey, 1986; Jessor & Jessor, 1975; Kazdin, 1987; Pandina & Schuele, 1983).

The MDFT approach has several distinguishing characteristics relative to many contemporary family therapy models. First, it is a *research-based*

approach. Although there are several well-articulated, empirically based family treatment models for adolescent problems (e.g., Alexander & Parsons, 1973; Alexander, Klein, & Parsons, 1977; Barton, Alexander, Waldron, Turner, & Warburton, 1985; Henggeler et al., 1986; Robin & Foster, 1989; Szapocznik, Perez-Vidal, Brickman, Foote, Santiseban, Hervis, & Kurtines, 1988; Szapocznik, Perez-Vidal, Brickman, et al., 1988), others exist outside of the context of systematic evaluation and research (Fishman, 1988; Jurich, 1990). Family therapy, however, is now in a new era, one that is less tolerant of approaches that lag behind in evaluation, or worse, are less amenable or receptive to research (Erickson, 1988; Liddle, 1991).

Second, MDFT is a *specialized model,* developed in a specific context for particular purposes. It specializes in treating the problem behavior syndrome (Jessor & Jessor, 1977) or the cluster (Kazdin, 1987) of adolescent problems of substance abuse and conduct problems. Philosophically, it is syntonic with those urging greater specialization of therapy model construction (Achenbach, 1986; Goldfried & Wolfe, 1988; Gurman, 1988; Liddle, 1990; Pinsof, 1989).

Third, this approach is appreciative of the problems with and the tendency of some models to endorse family reductionism—the crediting or blaming of health and pathology on the family. Accordingly, MDFT *emphasizes individuals* as systems and subsystems more than many other contemporary family therapy approaches.

Its *multidimensional focus* is a fourth distinguishing feature of this model. For example, integrating assessment dimensions, such as cognitive attributions, affective states, and recollections of the past, with communication and social skills training is not the usual fare for family therapy models. Another aspect of multidimensionality is the importance of extrafamilial factors (e.g., educational, juvenile justice systems) in instigating and maintaining adolescent problems. Peer, educational, and juvenile justice systems, for instance, must remain primary areas of assessment and intervention in any multisystemic, multidimensional model.

A fifth factor concerns the *integrative* nature of the model. Although still lagging behind the psychotherapy field, the integrative tradition in family therapy is beginning to take hold (Lebow, 1987). Still, most family therapy integrative models, particularly ones designed for adolescent drug abuse, have relied on models of family therapy for their sources of integration. For instance, approaches for adolescent substance abusers such as those outlined by Ellis (1986), Lewis and associates (1990), and Todd and Selekman (1990b) rely primarily on structural, strategic, brief therapy, behavioral, and systemic schools of family therapy. Existing within a family psychology framework (Kaslow, 1987; Liddle, 1987a, 1987b), the foundation of multidimensional family therapy aims to be more comprehensive than contemporary family therapy models. Many of these approaches, for

instance, underutilize basic knowledge of psychological principles and content (Liddle, in press-a).

A sixth distinguishing characteristic of MDFT concerns the *degree of emphasis that it places on the adolescent* in the context of family therapy for adolescent problems. The adolescent is a prominent figure in the successful conduct of this therapy, and treatment is seen as disadvantaged if he or she does not participate fully. Engagement, therefore, is a primary emphasis of the clinician's early work. We help the adolescent feel that therapy can be a context in which his or her individual concerns can be met. This chapter focuses on the crucial engagement phase of treatment.[5]

The seventh distinguishing aspect of MDFT relates to its integrative nature, emphasis on individuals, and extent of focus on the adolescent. Because of its centrality in MDFT and the degree to which other family therapy models make fallacious assumptions about adolescent development (e.g., Pittman, 1987), minimize individual adolescent development issues in the process of emphasizing parental empowerment (Haley, 1980) and correction of "incongruous hierarchies" (Madanes, 1981, 1985), or ignore normative content altogether (Fisch, 1989), we signify the *incorporation of empirical findings of developmental and adolescent psychology into our clinical model* as our final core characteristic. Although some have appreciated the need for this activity in family therapy (e.g., Stratton, 1988), we concur with the conclusions of those who argue that not enough has been done to place clinical interventions within a developmental framework (e.g., Furman, 1980; Kendall, Lerner, & Craighead, 1984; Shirk, 1988).

The MDFT approach, for instance, uses existing knowledge of how families serve as buffering or protective mechanisms to protect against the influence of deviant peer and societal influences (e.g., Burke & Weir, 1978; 1979; Greenberg, Siegel, & Leith, 1983; Larson, 1983; Steinberg & Silverberg, 1986; Wills, 1990), as well as empirical data on how positive family relations in the adolescent years fosters adolescent competence in a variety of ways (e.g., *self-confidence* [Ryan & Lynch, 1989], *self-regulation* and *exploratory behavior* [Hartrup, 1979; Hill & Holmbeck, 1986], *autonomy* [Steinberg, 1990], and *ego development of the teenager* [Hauser & Follansbee, 1984] *and the parent* [Hauser, Borman, Jacobson, Powers, & Noam, 1991]).

We should note that although family therapy certainly has had a broad-level appreciation of the role of family life cycle thinking in clinical practice for some time (Carter & McGoldrick, 1986; Falicov, 1988; Haley, 1973; Liddle, 1983; Solomon, 1973), the emphasis suggested in MDFT differs from a broad-level appreciation of the family life cycle paradigm, for instance. Many family therapists have a general sense of the importance of developmental principles as overarching metaphors in their work (Liddle, 1988a), but, in practice, do not utilize developmental knowledge in any substantive or systematic way. The case vignettes provide some examples of how this developmental content guided our interventions and assessment. Another publication details the fuller implications of the adolescent development literature in the construction of MDFT (Liddle, Schmidt, & Ettinger, in press).

Conceptual Framework of Multidimensional Family Therapy: An Overview

This approach draws from contemporary work emphasizing the continuous interplay and reciprocally determining *relationship between cognition, affect, behavior, and environmental input and feedback* (e.g., Bandura, 1978; Greenberg & Safran, 1984; Mahoney, 1984; Wachtel, 1977).

> *Conceptions of human behavior in terms of unidirectional personal determinism are just as unsatisfying as those espousing unidirectional environmental determinism. . . . Rather, human functioning is explained in terms of a model of triadic reciprocity in which behavior, cognitive and other personal factors, and environmental events all operate as interacting determinants of each other. (pp. 22–23, 18)*

Fundamental to the treatment model as well are the *ecological* (Bronfrenbrenner, 1983), *dynamic-interactional* (Lerner, 1978), and *interactional* (Magnusson, 1988) perspectives on human development. This holistic conception of development underscores "the organization and integration of capacities in various developmental domains" (Rieder & Cicchetti, 1990, p. 382). A final area of influence has been the still-emerging domain of *developmental psychopathology* with its basis rooted in a thorough understanding of problems in their developmental context (Achenbach, 1990; Cicchetti, 1984; Kazdin, 1989; Rutter & Sroufe, 1984).

Key assumptions of MDFT, drawn in large part from the theories briefly mentioned above, include the following:

1. People function simultaneously in numerous domains of human existence (e.g., affective, cognitive, behavioral, temporal, moral/ethical, spiritual, interpersonal).[6] This premise is hardly a new revelation. For over 20 years, the social cognition area, for instance, has contributed substantially to our understanding of the links between cognition, emotion, and behavior (Shantz, 1983). This sensibility is clearly present in contemporary mainstream psychotherapy as well (e.g., Greenberg & Safran, 1987).
2. These domains of human existence are interconnected, yet the mechanisms that govern these relationships are not always apparent.
3. In therapy, human problems can be accessed through these related domains of functioning. And, by implication, solutions to these prob-

lems can be generated within any one (or more) of these domains of human functioning.

4. Therapists are handicapped if they conceive of the primacy of one domain over another, or intervene only into one domain. MDFT aims to avoid a univariate focus at assessment and intervention levels.
5. At the level of intervention, in part due to our beliefs about the nature of human problems, a clinician is advantaged by having available multiple targets for change (i.e., human functioning is understood best by a multivariate focus and facilitated by a multimodal[7] therapist stance).

Overall Goals of Treatment

These are derived from the family's presentation of what each member wants from treatment as well as from generic formulations about families with adolescents (i.e., the importance of understanding both parental and adolescent subsystems). We do not see adolescent substance abuse as a manifestation of the "faulty launching" of the adolescent (Reilly, 1975, 1979, 1984), nor as a problem of failed separation (Levine, 1985). Models of this nature have, unfortunately, been developed on the basis of previous clinical work and research on young adult (vs. adolescent) drug abusers (Stanton & Todd, 1982). They are based on anachronistic conceptions of adolescence (e.g., a one-sided accenting of emotional detachment and separation). Models of this type also fail to take into account notions of interdependence (Steinberg, 1990) and autonomy-connectedness (Grotevant & Cooper, 1983).

Blechman (1982) warned the substance abuse field that the conventional wisdom of the times may not always be correct. Following this, for example, the enmeshment of the drug abuser with his or her family, and the inevitability of all adolescent substance abusers coming from dysfunctional families are two pieces of such "conventional wisdom" that have failed to be confirmed in recent research (Friedman, Utada, & Morrissey, 1987; Volk et al., 1990). Preliminary results from the AFP also indicate that our clinical families tended more toward disengagement than enmeshment (Liddle, Dakof, Parker, & Diamond, 1991).

With the developmental literature as a guide, MDFT signifies interdependence (Cooper, Grotevant, & Condon, 1983; Hill, 1980; Steinberg, 1990) in the parent-adolescent relationship as the delicate process we seek to foster. The continuing and redefined *attachment* of parents and teenagers (e.g., Greenberg, Siegel, & Leitch, 1983), tailored to fit the developmental idiosyncrasies of the second decade of life, and not detachment of the adolescent from the parents, orients the goal-setting process. Although we have speculated on the reasons why myths about adolescence endure (Eisner & Liddle, 1991), considerable agreement exists on the field's movement toward fresh thinking about adolescence. This modern era relies on empirical formulations rather than psychodynamically oriented speculations (Blos, 1979; Erickson, 1968; Freud, 1958; Hall, 1904). It transcends the narrow conception that adolescence is only about emotional separation from one's parents and advances multidimensional and ecologically oriented notions of adolescent psychology (Feldman & Elliott, 1990; Steinberg, 1990).

Multidimensional Assessment and Intervention

The approach assesses and intervenes into:

1. *Multiple Domains in Which People Exist (e.g., cognitive, affective, behavioral, temporal).* Human beings and human problems are complex and multifaceted. Following this appreciation, contemporary psychotherapy challenges us to construct sufficiently complex models of assessment and intervention. Any single approach, particularly one that resides in a singular, "pure" model tradition, may be too limited in scope and not specific enough for particular clinical phenomenon and populations. This position asserts that the *schools of family therapy,* as we have known them in the past at least, have outlived their usefulness (Liddle, 1990).

2. *Multiple Subsystems in Which People Reside (e.g., individual, marital, parental, extrafamilial, peer, sibling).* Modern-day family therapy recognizes the difficulties inherent in family reductionism.[8] Family systems work does not infer that the entire family should be the only unit of focus. In addition to extrafamilial contexts such as the juvenile justice system and the schools, MDFT places primary importance on the therapeutic alliances between therapist and parent(s) and between therapist and teenager.[9] These are distinct relationships with their own course, expectations, and contract for what therapy can and will be. Success with one family member does not in the least guarantee success with the other. In fact, the complex connection between these relationships is revealed when we consider that success in one of these relationships (e.g., the therapist-parent[s] subsystem) may in fact lead to difficulties in the other (e.g., the therapist-teenager relationship).

3. *Multiple Content Realms in Which Personal and Relationship Problems Reside (drug and alcohol abuse, family and individual development, problems as they exist in the present and are remembered from the past).* This area refers to the fact that human problems may be presented in a clinical situation in various forms. We believe that the context of therapy is vitally important—that clinicians make decisions about specific content themes that will be carried forward throughout therapy. These content

themes are varied and can be transformed during the course of treatment. They are related to generic themes of family life, as well as to a family's idiosyncratic "big questions" (Liddle, 1985, 1988). MDFT devises its content themes from the generics of family life, as well as from the particulars of family life with adolescents and the individual and subsystem development of each member. We actively incorporate research findings from the adolescent development literature into our clinical work. For example, findings that indicate how adolescent identity development is fostered through a continued familial interdependence rather than an emotional separation (Grotevant & Cooper, 1983) or the influence of different parenting styles on adolescent personality development (Baumrind, 1991; Steinberg, 1990) become guides to goal setting and intervention.

4. *Multiple Methods and Pathways to Prompt Change.* The approach works for in- and out-of-session change, and assumes change to be multiply determined. Such change, occurring at individual, dyadic, multiperson, or familial levels, can be prompted in myriad ways (e.g., via reformulation of cognitive attributions, practice via behavioral rehearsals, greater acceptance of another through emotional expression and clarification). This change has affective, cognitive, and behavioral components; it is not simply continuous *or* discontinuous in nature, as some would have it (Hoffman, 1981) (both are in operation; see Liddle, 1982). MDFT recommends a flexible, multimodal therapeutic stance and uses several key modules or units of treatment across cases. This chapter deals largely with the adolescent module in MDFT.

Drugs, Etiological Agents, and Problematic Epistemologies

Multidimensional family therapy is a subsystem therapy[10] designed to alleviate the presenting problem of drug abuse. Adolescent drug abuse is defined contextually. It is not seen as a disease of the adolescent, or, necessarily, as an addictive process. Although proponents of the disease model of adolescent substance abuse, or chemical dependency as it is also called, express a righteous certainty in their view, years of careful research do not support these firm assumptions. Despite warnings about the difficulties in identifying and differentiating between antecedents, concomitants, and consequences of adolescent drug abuse (Kandel, Kessler, & Margulies, 1978), reductionistic thinking is in no short supply in the adolescent substance abuse field (Alexander, 1990; Peele, 1986b).

In the MDFT approach, the abuse of drugs is understood in the ecology of the teenager's life, which is frequently manifested by multiple problems, such as poor relationships, cognitive and problem-solving skills, learning and school difficulties, low self-esteem, family stress or dysfunction, and movement onto a trajectory of failure and incompetence. Substance abuse is thus defined as existing in a context of other, interrelated problems, each of which might have to be addressed.

Just as the model is defined multidimensionally, problems are defined multidimensionally—as having several facets that must be assessed and targeted for change. This perspective is drawn from modern-day thinking and research about drug abuse and other behavior problems of adolescents. Several causal factors are related to drug use initiation and maintenance (Newcomb, Maddahian, & Bentler, 1986). For Brook and colleagues, there exists a network of influences on adolescent drug involvement (Brook, Nomura, & Cohen, 1989).

Today, unidimensional theorizing about the etiology and treatment for adolescent drug abuse is a distinct minority position. The cutting edge of thinking and research in this area has moved beyond articulating single variables or domains that influence initiation and maintenance of adolescent drug abuse, to questions about the interconnection and interaction of these individual factors.

> *Drug use among teenagers is one component of an integrated life-style involving attitudes and other behaviors. Thus a strict focus on teenage drug use will be too limited for effective prevention or treatment. At an individual level, the surrounding and correlated aspects of drug use must also be carefully considered and integrated in programs (Newcomb & Bentler, 1988, p. 236)*

Many other contemporary theorists and researchers have called for a similar approach to understanding adolescent drug abuse. Often referred to as a *problem behavior syndrome* view (Jessor & Jessor, 1977), this framework casts the deviant behaviors of adolescents within a network of other correlated behaviors (Loeber, 1985; Elliot, Huizinga, & Ageton, 1985). In a careful meta-analysis of 143 adolescent drug prevention programs, Tobler (1986) concluded that simplistic, information-only approaches to prevention were ineffective. Because drug-abuse problems are complex, Tobler recommends that programs for teenage drug use should be multidimensional and linked with other interventions, such as the teaching of coping skills and the generation of realistic alternatives to drug abuse.

Pandina and Schuele (1983) have also recommended a multivariate approach to adolescent drug abuse. They suggest a multicausal, interactive framework that considers intrapersonal, extrapersonal, and sociocultural levels of analysis, with factors from each level acting simultaneously to influence use behavior.

> *A major implication of this view is that efforts toward prevention and rehabilitation aimed at changing adolescent alcohol and drug use may not be*

> *maximally effective if they are limited in focus to the use behavior itself or on an isolated domain of the adolescent's life. Instead, interventions should focus simultaneously on multiple domains. (Pandina & Scheule, 1983)*

In his work with antisocial child behavior problems, Kazdin's (1982) guidelines for treating the problem behavior syndrome are also applicable to adolescent substance abuse. Kazdin's *cluster theory* formulation includes the idea of "response covariation" (i.e., the interaction of problem behavior with other problem behavior and with other behaviors in general) as a method to conceptualize the nested relationship of problem behaviors to each other.

> *Research on response covariation has potentially important implications for administering treatment. Changes in problems presented in treatment can be achieved in different ways. The most obvious way is to focus directly on the problem, the usual thrust of treatment, even though the presenting problem is defined quite differently across treatments. Alternatively, a particular problem area may be altered by focusing on a correlated area of performance. At first glance, there may be no obvious value in attempting to treat a problem indirectly by focusing on a correlated response. Yet, for some clinical disorders, the correlated behaviors that may influence the target problem may be more readily accessible or responsive to the intervention. (Kazdin, 1982)*

These frameworks would give the term, *substance abuse problem,* a less precious and specialized ring to it than is frequently the case, especially in the chemical dependency community. Thus, we stand with Peele (1986b) in objection to the connotations and consequences of mindlessly adapting models of addiction to adolescents.

The 250 teenagers in the Adolescents and Families Project had significant problems with life, in addition to their problems with the abuse of drugs and alcohol. Adolescent drug abuse creates a developmental lag in teenagers' maturation (Baumrind & Moselle, 1985); as a result, adolescents who abuse drugs often fail to learn necessary life skills, and contribute to the creation of a family context characterized by disorganization, distance, and despair. In light of the considerable evidence on the family's capacity to serve as a buffer against the drug abuse of its youth (Baumrind, 1991; Brook, Brook, Gordon, & Whiteman, 1984; Brook, Brook, Lettieri, & Stimmel, 1985; Brook, Whiteman, Gordon, & Brook, 1985; Burke & Weir, 1978; Glynn, 1984; Gorsuch & Butler, 1977; Greenberg, Siegel, & Leitch, 1983; Larson, 1983; Wills & Vaughn, 1989), the promising effects of family therapy for adolescent substance abuse (see reviews by Davidge & Forman, 1988; Stanton, 1991), and the consensus on the need for multivariate conceptualization of adolescent problem behavior, it clearly seems wise to invest in family systems models of treatment.

Engaging the Adolescent and Setting the Foundation for Therapy

Working with adolescents and their families necessitates serving at least two masters: the parent(s) and the adolescent. Structural and strategic models of family therapy have primarily focused on instituting parental control and authority by establishing the hierarchical organization of the parents vis à vis the teenager (Haley, 1980; Madanes, 1981, 1985; Minuchin, 1974). The goal was to have hierarchical incongruity corrected (i.e., parents in charge of their children). Although we appreciate the importance of parental empowerment in the realm of control, there are additional aspects of parenting adolescents that have been found to be important (Baumrind, 1991; Greenberg, Siegel, & Leitch, 1983; Siegel, 1982) (i.e., empowerment is possible in other realms as well).

Beyond Control: Facilitating Development in Multiple Realms

The MDFT approach urges greater attention to other dimensions in the therapy in addition to parental hierarchy. Although authority and control are important dimensions in therapy with teenagers, they are by no means the only or even the primary variables of our interest or focus. In fact, in therapy with adolescents, *overfocusing* on the reestablishment of parental control is developmentally inappropriate and hence could be counterproductive to the accomplishment of key therapeutic goals. Pragmatically speaking, an overemphasis in this direction can also prevent the therapist from engaging the adolescent effectively in therapy, which will of course deter opportunities to establish an agenda for the teenager. The phrase we used with the adolescents, "There can be something in this for you," literally and metaphorically represents an important aspect of MDFT.

This engagement of the adolescent and the definition of an agenda for him or her in therapy is a primary goal in MDFT. It requires the therapist to work with both parental and adolescent subsystems simultaneously, even though the activities in each may seem contradictory.[11] The therapist can increase the probability of success with the teenager by taking a posture of respect and support for the adolescent's personal experience, both inside and outside his or her family.

This therapeutic posture is not one of "child saving" (i.e., a unidimensional, partial perspective that ignores the realities and experiences of the parent[s]), but rather one of acknowledging that the adolescent has his or her own story to tell. The therapist must honor the therapeutic promise to the teenager that his or her story can be "heard" in this therapy. This is especially important because drug-using teenagers have been found to expe-

rience a lack of personal agency or control over their own lives, and relatedly, feel a profound meaninglessness or lack of direction (e.g., Newcomb & Harlow, 1986). MDFT addresses these influential, organizing themes by, among other interventions, working alone with the adolescent for significant periods at all stages of therapy.

In this chapter, by analyzing portions of actual therapy sessions from the AFP, we will illustrate how we work with drug-abusing teenagers and their families.

Case 1: "There Is Something in This for You"

The following case excerpts, which come from the end of session 1 and the beginning of session 2, illustrate how one might develop and work with the *content theme* that we call "There is something in this (therapy) for you." The adolescent, in this case, is a 16-year-old boy, Sam, who is the youngest of four children. At the time he entered therapy, Sam regularly used alcohol and marijuana. He had severe school and behavior problems since the second grade. Sam had difficulty expressing himself verbally, and instead often resorted to violence. This seemed to be his predominant way of dealing with his hurt, anger, and disappointments. By the time Sam came to the Adolescents and Families Project, most everybody else (i.e., schools, other therapists, probation officers, his parents) had given up on him. They had judged Sam to be too out of control, too violent, too incompetent, and too unintelligent to be a good therapy candidate. One goal with Sam was to support his feelings, while at the same time, help him change how he expressed those feelings. We tried to transform his language and behavior in a more civilized and appropriate direction. Although his parents separated a year ago, they both agreed to attend therapy.

The therapist[12] spent most of the initial session talking with the parents about family history and current problems. During this discussion, Sam was somewhat indifferent and periodically belligerent. He was seen alone for the last 10 minutes of the session.

"I Think We Could Do a Lot Here"

Therapist (T): So what do you think of this?

Sam (S): It's cool.

T: You've never been in therapy like this, have you?

S: No, not like this.

T: Do you feel nervous, do you feel . . .

S: No. (matter of factly) It's just another counseling.

T: I don't think it's going to be another counseling. That's not the way I work. I think we could do a lot here. But I guess one thing I want to know is whether you're going to work with me. You know what I mean by that? (Sam nods.)

T: (a few minutes later) You see, I'm really interested in who you are, and I really want to know more about you. I want to know who you are in this family, and who you want to be, as your own person, Sam. But I'm going to need your help. Do you think you can help me with it?

S: I can try.

The therapist begins to set the foundation for engaging the adolescent in therapy. The therapist established his expertise and confidence, tested whether Sam is willing to accept an injection of optimism, and acknowledged that he has a point of view that needs to be expressed. Since the family, schools, police, and juvenile justice systems generally see these adolescents along constricted, pathological lines (antisocial, addicted, disturbed), asking for a teenager's help can create a new relational experience that counters the biased conceptions that the adolescent has about adults in authority. The attributional set of adolescents, parents, extrafamilial sources of influence, *and* the therapist are all equally central to this approach.

"That's Something We Could Do Here"

T: Well, you told me last week that when the big fight happened with your father, you don't like dealing with your anger that way.

S: I don't, man, but that doesn't mean any of you are gonna make me change. . . . Maybe I'm wrong, I'm not saying I'm not.

T: Would you be interested in learning how to deal with things better?

S: (pauses) Yeah. I am.

T: That's something we could do here. (pause) You know, you didn't look so happy when you were hitting your dad. (Sam kicked and hit his father in the family assessment the previous week.) And you told me you hate when you get mad at him. I didn't think you looked too happy. Tonight I felt like there were times when you weren't happy. You didn't like what they were saying, maybe you don't feel like they understood you enough. Maybe you feel like you get in between them. You know, it's a hard situation, your parents being split up. They're still working out their things. It's going to influence you. I know that's rough. So, I want to help you work through some of that in a way that would work out good for you. But I'm gonna need your help.

We look for opportunities to develop positive themes and goals with the adolescent and parents (i.e., behaviors that need to occur more frequently). In addition, the therapist actively searches for and emphasizes the adolescent's thinking and feelings about his or her current circumstances. And, with even the most profoundly abdicating parents, there is often something in what they say that can be embellished and expanded into a theme ("I'm worried about him" or "I wish I could be a better parent"). With the adolescents, in order to help craft themes, we search for some—

even slight—indication that he or she is unhappy and might like something changed. These nuggets of possibility, often obscured in a larger stream of unproductive conclusions, must be recognized, highlighted, and carried forward within sessions and from one interview to the next. In the previous sequence, for instance, the therapist reminds Sam of a previous statement he made about not being happy when he lost his temper with his father. Statements such as these are used as motivation-enhancing reference points throughout treatment.

We utilize the social reality of the adolescent already being "on the record" (i.e., having said that his behavior makes him unhappy or that he is willing to examine or try and change). We *carry forward* these themes, or "partial truths" (Minuchin & Fishman, 1981), and lend them back to the adolescent or parent. It is often most important to remind the client of this sometimes forgotten theme during times of difficulty in treatment, such as when the motivation of the adolescent or parent is flagging. In the case under discussion, by latching on to Sam's previous statement about how he would like to find a better way to handle his anger, the therapist demonstrated to Sam that his words are remembered and taken seriously. This statement on the teenager's part, which sometimes appears as an afterthought or as a minuscule part of a broader message, is used to remotivate the adolescent during difficult times, or, in the early stages of work, to help depict therapy's possibilities.

As we said, Sam was presented to our project as a teenager who was a poor therapy candidate. The area of Sam's feelings was something that most people believed should be avoided. He was typecast as a youngster whose predominant feelings (and those that he was most adept at communicating) were anger. We began our work with Sam with the multidimensional assumption that Sam's affective world was more complex than anger. Although clinicians often avoid an adolescent's emotional world, assuming they are unable to work in this realm, we have a different orientation in this regard. Working the affective realm with adolescents alone early in therapy potentiates access to other areas of functioning (e.g., core cognitions about self and others). Further, it can facilitate engagement and establish an agenda for them in the therapy. Importantly, it distinguishes the therapist as a person who can understand them, confirm their right to have and present their perspective,[13] and as one who, sometimes at least, takes their side.

"Will You Let Me Challenge You?"

T: What does that all sound like? Do you want to give it a try?

S: (indifferently) Yeah.

T: Would you like to see things change?

S: Sure.

T: What kind of things? What would you say?

S: I don't know, just how I get along with everybody.

T: Do you feel like you get along with your mom now?

S: Yeah. Better than I used to.

T: How about your dad?

S: All right.

T: It sounds like he would like to be closer to you. Is that something you share also?

S: I don't know.

T: You don't know? Hum . . . Well (pauses) . . . it's perfect that you say that, because that's exactly the kind of thing I'm gonna ask you *not* to do. I'm going to ask you to struggle with things in here, and say "Yeah, this is what I hate or this isn't what I want." Even when it's difficult. Because I know you've got a voice in there that wants things. But sometimes they're hard to say. You're afraid you're gonna hurt somebody, or get angry at them, or you might not get what you want. But I want to help you to be more straight with them.

Assessment and challenge are two important themes in this sequence. The dialogue served simultaneously as an intervention and assessment. The therapist attempted to obtain answers to the following questions: Is the adolescent willing to respond to the framework that the therapist is offering? Can the teenager identify with these concerns and begin to articulate his own story? What are the adolescent's leanings about the possibility of a therapeutic relationship at this early point?

Whereas some adolescents will quickly respond to the therapist's offer of empathy and understanding, others remain not only distrustful but hostile toward the therapist's attempt to access their emotional life or private thoughts. However, it is important to recognize that the teenagers' suspicions or apparent emotional fragilities are not the only determinants of their degree of disclosure. Intellectual ability and interpersonal skills also affect the adolescent's capacity to have the kind of discussion we seek.

Another theme here concerns the definition of a relationship that will serve as a context to develop new relational and conceptual skills. In essence, the therapist tells the teenager that it is important for him or her to communicate more effectively with the world, and in a sense with himself or herself, about one's reactions and experience.

In the above segment Sam's tentative responses are a cue not to push too much at this point. In establishing alliances and content themes, the therapist continually calibrates the pace of setting the therapeutic agenda according to family members' receptivity. By meeting Sam's pace, but sometimes extending the apparent limits, the therapist and Sam together

coestablish a session's pace. During this session the therapist said, "Listen. There is no reason that you should trust me yet. Think over what I have been saying and let's talk about it next week." Here, the therapist intends to reduce the pressure on Sam, show him respect, define what some elements of therapy might be, and help him participate in modulating therapy's process.

"Can You Be Straight with Your Parents?"

Establishing a link to the first interview, the therapist began the second session by meeting with Sam alone. New information, as it emerges, must be factored into therapy.[14] Prior to this session, Sam had received the news that his probation officer wanted to send him to a boys' camp for one year because he hit a teacher at juvenile hall. We used this crisis to heighten the importance of Sam's participation in treatment. The segment begins with Sam explaining that if he is sent to the camp, he will run away.

S: I mean, I don't care about doing time—even if my parents. . .

T: What do you mean, you don't care about doing time?

S: Oh, I care about doing time, but I mean, I'm not . . . I mean it's not . . . it's just that I don't want to be that far away from my parents where I can't . . .

T: Sam! I don't get it. I appreciate that you want to be around them, but how does it happen that you get in such tangles with them?

S: Just when they keep . . . I know it's stupid, but they just start . . . I don't know, man, my dad just starts arguing and I snapped out. I know they're not going to get back together, but it still hurts me when they start arguing, even if it's over pity shit. It was over the food . . . I don't know, man.

T: I want to ask something of you tonight, and it's going to be really hard, because I think you're in a lot of pain in this family, right?

S: Kind of.

T: What?

S: Yeah. Maybe.

T: You admitted it to me the first time we met!

S: I know.

T: Within five minutes. Why don't you like to admit it?

S: I'm just trying to be . . . I don't know, man. (starts to cry) Everything is just messed up.

T: So, you try to be tough so nobody knows you're hurting? Does it feel safer that way, or . . .

S: Yeah, usually then people don't ask me what I'm feeling.

T: People don't ask you questions because they just think you're wild and out of control? (Sam nods) Well, that's what I want to know if you'd be willing to do tonight.

S: Do what?

T: To really talk with your parents about how upset you are. Because I think they would have a whole different take on you if you could be straight with them.

Sam begins an important process. He is starting to share, what we might call, the story of his life. The segment illustrates how the affective realm is used, in part, to engage the adolescent into the therapeutic process of examining one's life and generating alternatives. (Obviously, work in the emotional domain is also done with the parents as well). Again, MDFT targets multiple realms of life for assessment and intervention. The affective realm is but one of several targets of the therapy. Not all teenagers are willing or able to talk about their emotional disappointments, *nor is it necessary for every adolescent to do so.* To clarify: In this approach, catharsis or emotional expression, *per se,* is not a goal of the therapy. However, conversations about one's feelings are one important aspect of multidimensional work. They are a pathway to creating individual change, solidifying engagement, establishing and maintaining alliances, and helping family members establish new and salubrious ways of being with each other.

In this sequence, the therapist facilitated Sam's description by empathically appealing to the affective side of the story. Affective content became a therapeutic foundation with Sam and his family. This addresses the question: "Can I create a setting in which (partly as a result of his interactions with me) Sam can relate to his parents in new ways?"[15] At the outset of such hoped-for transactions, as was the case here, it is sometimes sufficient simply to have adolescents sort out, in conversation with the therapist, their many and frequently overwhelming feelings. Ultimately, however, an important goal with this teenager, and with many others, was the development of a *new language.* This term is a metaphor to describe new ways of adolescents relating their experience to the world. This expanded self replaces the defiant acts and self-administered anesthesia (e.g., alcohol and drugs) with more functional thoughts about self and others, feelings, and behavior.

Subsystem Work: Wholes and Parts Finally, we understand these conversations as both wholes and parts, in part, thanks to the conceptual work of Koestler (1979, p. 33) and the application of his work in family therapy by Minuchin and Fishman (1981, p. 13). Each conversation between therapist and adolescent (and therapist and parent) has potential value, in and of itself. Contrary to what a radical family therapy philosophy would have us believe, people do not change only in relation to other family members. One aspect of change occurs, as it might be put, at the level of the

individual, as a system (and a subsystem in relation to the family and other social systems).

Reductionism at the family level is changing in family therapy (Liddle, 1991a). Thankfully, and as strange as it may sound, there is a renewed sense of the *importance of individuals* in family therapy (Nichols, 1987; Schwartz, 1987, 1988). In individual sessions in MDFT, teenagers can be heard and responded to, sometimes as never before. Family members can be helped to sort out their intensely experienced and tangled feelings and thoughts, and, by using progress in these realms, they become more skillful communicators. The increased competence of the adolescent and the parent creates a new, motivating reality for the other.

This is the "whole" aspect of the clinician-adolescent subsystem therapy. But this subsystem work can also be considered as a "part." Conversations such as the one with Sam illustrated above, which can occur at any stage of therapy, also serve a *preparatory function*. As we have said, for various reasons, the teenager or parent at the outset of therapy may not be able or ready to begin talking with the other. For instance, how does a clinician understand the adolescent's lack of ability? Skill deficits, a lack of readiness, the blocks of emotional history, as well as strong negative attributions may all interfere with effective communication. While the conversation with Sam has potential healing functions with the adolescent as a self, it simultaneously readies Sam for action in relation to his parents.

Case 2: Shifting Domains of Operation in a Session

The next case elaborates the idea of *preparation for enactment*. Now we examine the preparation of both the daughter and the mother, and detail the "thought rules" and techniques of initiating a conversation about a disturbing family theme. In the following segments, we see how a therapist shifts focus when his in-session assessment indicates limited results with a straightforward problem-solving approach. Learning the skills of and developing personal ground rules for *therapist improvisation*—the change of one's intentions in a session—is the heart of clinical technique. Too often our teaching fails to help students acquire an appreciation of how to think through interventions and intervention planning to this level of detail. Consensus on how these instincts can be taught and how evaluation should proceed in this area has not been reached (Avis & Sprenkle, 1990; Liddle, 1991c).

"I Want My Daughter Back"

Jim and Marina, divorced for many years, have two daughters: Sally, age 15, who resides with her mother and stepfather, and Cynthia, age 20, who lives on her own. Marina sought treatment for her younger daughter's drug use (marijuana and alcohol), poor grades, and their progressively distant relationship. Sally's stepfather was decidedly uninvolved in childrearing tasks. Marina was concerned with Sally's drug use as well as with Sally's increasing involvement with her girlfriend's family. Marina believed that her daughter was drifting away from her toward what Sally called her "adopted" family. This environment permitted drinking and other freedoms that ran counter to Marina's values.

Abandonment was a central theme in this case. Themes such as this one exist in and can be accessed through a variety of domains. For instance, in the temporal realm, it is difficult to imagine addressing the topic of emotional or physical abandonment without dealing with issues of the past. Exploring attributions about abandonment makes available the relevant core cognitions (e.g., "Perhaps I am unworthy of love"). Perhaps the most commonly thought of way in which the theme of abandonment is materialized in sessions is through the affective realm. The intense feelings that come with the memories of being abandoned or neglected, as well as those feelings that accompany the parents' experience of their own behavior, are key domains of therapeutic operation.

In this case, the daughter felt abandoned by her mother, who said explicitly that she was choosing to protect her second marriage at the cost of isolating her daughter. Marina, seemingly unaware of the impact of this stance on her daughter, felt abandoned by her daughter as well. Sally's emotional involvement with her new family, although it gave attention and security to Sally, was difficult for Marina to accept. In situations like this one, in which there are powerful affective themes, problem-solving and negotiation strategies can easily fail.

Therapist Improvisation: Shifting Domains of Operation The key principle illustrated in the following sequences is the therapist's shift from a problem-solving to an affective dimension. A multidimensional model allows the clinician maximum flexibility for in-session work. In the present case, at the previous session and the beginning of the current session, Marina expressed extreme pessimism about her daughter. The clinician was aware of mother's pessimism and was looking for productive ways to address and, if possible, counteract it. The therapist decided to challenge mother's pessimism in a straightforward, problem-solving way by trying to work a conversation about mother and daughter having dinner together (a rare occurrence). When the therapist assessed that this approach was not working, she shifted the focus from the problem-solving on this content to the affective dimension. In the first segment, we see a lack of movement in the behavioral and cognitive dimensions.

"Let's Get Something Accomplished"

The therapist is clarifying her rationale for requesting mother and daughter conversations in the session.

T: What's this about? Well, it's about having a relationship with your daughter. It doesn't necessarily mean it has to be as formal as a date.

Mother (M): (interrupts; seems *frustrated*) Well, it does because she doesn't want to have *anything* to do with me. I mean, like if I walk in and talk to her . . .

T: But you can do stuff together. What about dinner, what about doing stuff, you know . . .

M: She won't have dinner with me. She *will not* sit down. She *has not* sat down and had dinner with me for two years.

T: Would you like her to have dinner with the family?

M: Sure, it's normal. Sure.

T: So, what do you have to do? What are the kinds of things that go into this? Let's not assume that that's out the window.

M: It *is* out the window. (discouraged)

T: Mmm.

M: Well, I mean, after two years it is.

T: (sits forward and addresses father) Jim, can you convince this lady that she's got more influence over this kid?

M: (interrupts, sounding a bit insulted) Well, I don't have the energy to go in and scream and yell and pull her out everyday. I mean it's . . . You guys make this sound like it's really easy, and it isn't.

Working to forge an agreement about having family dinner together, the therapist begins to realize that work on this problem is both complex and intertwined with other issues. The intervention targets the cognitive (i.e., the level of meaning of an event in the family) and behavioral realms (i.e., logistics and skills in making the plan happen). As the therapist continues to focus on the possibility of mother and daughter achieving greater contact through the dinner, the mother's pessimism emerges. The father is included as a temporary move on the therapist's part to help change the mother's mind. However, mother felt pushed and unsupported within the context of a relationship with her daughter that itself felt unsupportive. In this situation, the therapist must change her stance immediately or risk mother's disengagement.[16] The therapist makes a dramatic shift.

Intentionally Shifting Focus in a Sequence The therapist asks Sally to leave the session for a few minutes.

T: (to mom) I wanted Sally to step out because I think you're feeling ganged up on, and that's not what . . .

M: (interrupting) I feel *really* ganged up on. You guys make it sound real easy and it's not. (Mom laughs nervously)

T: That's not what I'm about, okay? That's not what I'm about. I'm here to try to make life easier for you. Do you believe that?

M: Well, maybe. I don't know. (laughs; doesn't sound convinced)

T: No. You don't. Okay.

M: I'm really tired of convincing others . . .

T: If that's where it's at, then that's what we need to be talking about. (pauses) Are you mad at me right now?

M: No. I'm just mad at the whole thing. I'm mad . . . Sally doesn't care about having a relationship with me, and it seems like if I try it's . . . you know, after a while you think, gee, this kid just does not want a mother. Maybe she doesn't want a father. She doesn't care at all. (sounds upset, discouraged, frustrated)

This type of dialogue continued for about 20 minutes. It ends with the following statement from the therapist that reaches Marina.

T: (to mom) So why are you doing this (coming to therapy, trying to reach out to your daughter)? You're doing this because you *love* her and you're *concerned* about her. You've already lost your older daughter to drugs. And you don't want this for Sally. You never wanted this for your older daughter. And it's *painful* and it tears you apart, and *that's* why you're here (in therapy) . . . that's why you want to do this, as *hard* as it's going to be. (pause) And I don't want you to feel like I am ganging up on you, or Jim is ganging up on you. I want to be here for you, Marina. Because I've seen how tough this is. I know it's *tough.* And my heart goes out to you, and I will do everything I can to be supportive of you.

This segment contains several important shifts. First, the therapist shifts the focus of the session from the daughter (e.g., "Are you interested in having more of a relationship with your mother?") to the mother (e.g., "I think you're feeling ganged up on"), and, perhaps more importantly, to the therapeutic alliance between Marina and herself (e.g., "Are you mad at me right now?"). By asking Sally to temporarily leave the session, the therapist sends a signal of respect to the mother (i.e., "I sense your upsetness and I want us to deal with that").

The shift from mother-adolescent problem solving attends to Marina's experience and individual needs of the mother. Another shift occurred in the locus of the therapeutic action. Instead of working either directly or indirectly with the mother-adolescent interaction, the therapist brings herself and the mother into the center of the process. This use of self by the therapist is constituted by a willingness to address her relationship with Marina. These moments illustrate the sincerity and credibility that have been established between therapist and mother. The therapist draws on this capital in times of crisis.

These are difficult moments to manage. Even with a clear session plan, a clinician's failure to read the feedback of the moment, especially in the affective and therapeutic alliance domains, increases the risk of iatrogenic effects. Feedback about a family member's reaction to the session's events (and to the therapist) are a challenge to read and to know how

to respond. The ground rules for being attentive to and reading feedback can be made explicit and depend on lucid personal judgment under difficult conditions (Liddle, 1985). In this sequence, although the therapist had a specific agenda for the session, she appropriately adapted her style, content, and focus to accommodate to the feedback from her interventions.

In this segment, Marina and the therapist deal with hopelessness and the difficulty of resuscitating parental commitment. Aspects of this conversation include: (1) confirming the mother's anger ("I think you're feeling ganged up on") and despair ("You are really angry and frustrated"); (2) compassion for the difficulty of her situation ("This is really hard for you"); (3) normalizing the behavior ("Anyone would find this hard"); and (4) offering new explanations ("She is not used to you reaching out to her") and resuscitating commitment ("You love this child"). While recalibrating the session's emotional tone, the conversation also influences, in the moment at least, the mother's attributional set. It redirects her from a set that negatively connotes Sally's feeling state (e.g., "'My daughter doesn't care about having a relationship with me") and lack of motivation for a relationship with her mother (e.g., "This kid just does not want a mother").

Preparing the Daughter In the previous segment, the therapist asked Sally to leave the room so the parents could be talked with alone. Before she asked Sally back into the session, the therapist met briefly with her alone. She tried to prepare Sally for subsequent work with her mother. Sally was challenged to "rise to the occasion" and take her own desire for independence more seriously.

T: (to Sally alone) Go back in there. Don't be a kid with your mom. Don't protect her. Be straight with her and let's see where it can go. I'll be there to help if you need it. I'll support you in this.

Sally agreed to try and therapist and Sally went back to the session.

In the next segment, the mother's change in affect and intent is clear. The previous therapist-mother interaction helped Marina out of a blamed and blaming posture and placed her in a vulnerable spot vis à vis her daughter. She is now ready to reach out to Sally, perhaps in a way that could move her daughter to complementary behavior. By meeting alone with Sally, the therapist tried to facilitate her accessibility to Marina. As she asks mother and daughter to try again, the therapist must monitor Marina's ability to remain in this emotionally available position. As the conversation unfolds, the therapist tracks Sally's understanding of what her mother is doing and, ideally, helps her to respond in kind. In tandem with this, the therapist tracks Marina's continuing ability to maintain the positive tone she has achieved.

Sally originally sat on a couch with her mother, across from Jim. In order to intensify the mother-child proximity, the therapist moved Sally to the chair across from her mother on the couch.

T: (To Sally) I want you to turn your chair to your mom. Your mom has told me some things just now that I thought were really important. And I want her to have a chance to say these things to you directly, because I was very moved by some of what she said. Okay? (The pace is intentionally deliberate and the tone is serious.)

M: (sadness in mom's voice) Well, first of all, it's very hard for me to talk, because I feel so bad about all this. I feel the loss of a daughter. I *miss* you. There's things that I want to do with you. I want you to be my *daughter*. I mean . . . and you don't want any part of it. That's very hurtful. (pause) I see mothers with their daughters—they enjoy each other's company and I just feel like you want nothing to do with me. (Mom begins to cry) You're home only because you have to be home. We have to make all these rules just so that maybe I can squeeze in some time to be with you. You really don't want any part of that. (the upset emotional tone changes slightly) I came from a family of mothers and daughters. I was close to my grandmother who had daughters. I was close to my mother who had daughters. I was even close to her sister, who also, you know, kind of adopted Auntie and I because we were daughters. That's a very special thing. (becoming upset again) I lost one daughter (a reference to mother's estrangement from her oldest child) and now I'm losing another daughter . . . It's not . . . (stops talking, at momentary loss for words)

T: And you don't want to lose her.

M: No. (emphatically)

T: And you don't want to have to make rules, but you don't know how to connect with Sally, you don't know what to do. (Sally was, up to this point, not responding very much to her mother's efforts. The therapist continues to encourage her.)

T: (in a soft voice to Sally) Your mother is being particularly open right now, Sally. She's not saying this to hurt you, she's saying it because she feels so sad and she loves you so much. Help your mom right now. Help her to know how to have a relationship with you. (pause) I don't believe for a minute that you don't miss it too, Sally.

Sally has her head down and is crying. The therapist hands her a tissue.

T: I think that's why you're crying right now. I don't think you want your mom hurting like that. Why is that? I think it's because you love your mom. Talk to her, Sally. (long pause. The therapist gets up and moves next to Sally. She puts her arm around the girl's shoulder.) She's hurting. Do you want her to hurt like this? I know you don't. Talk to her. She *loves* you. She's frustrated, she's hurt, but she loves you and she wants to talk. (pause) Would you like to try? (pause) Would you like to try? (long pause. Sally continues to cry quietly while her face is buried in her hands behind her hair.) Okay, come with me. (Sally accompanies the therapist out of the session.)

Shifting gears, the therapist now attempts a "hallway intervention." She has attempted to help Sally respond more clearly to her mother, but on

this occasion, it is difficult for the daughter to do any more than she has done. The therapist, so as not to unduly disrupt the session and to give this conversation a reasonable chance of achieving even more success, speaks to Sally in the hallway. The intent is to assess quickly Sally's feelings about what is happening, as well as determine her willingness to respond a bit more fully with her mother. They return to the session with the therapist not sure how far Sally is willing to go on this occasion.

T: So, Sally, tell your mom what's going on.

S: I don't know. (sobbing voice)

T: (challenges) What do you think about the things she said? (pause) Sally, why are you crying right now? (Sally's head is bowed and her hands are still covering her face.)

S: (to mom, in a sobbing voice) Because I . . . I don't want you to feel that way.

M: Well, how else can I feel? I mean . . .

T: (strong, challenging) Why don't you want your mom to . . . Why do you care? Why?

S: Because I love her.

T: Then, tell her you love her. Tell her what it means to see her in so much pain. Tell her about that. (pause; voice softens) Your mom needs to know you love her.

S: She knows.

T: No, she doesn't know, Sally.

S: (to mom) You don't know?

M: Well, I think you sort of love me, but I think you sort of love to be away from me. You don't want anything to do with me. Nothing.

T: That makes you feel unloved.

M: Very unloved.

T: That's why I'm saying—I don't think your mom really knows that. Loving someone means, "I want a *relationship* with you. I want a connection with you. I want you to know when I'm scared. I want you to know when I'm happy." (pause) I'm saying you need to let your mom know. If that's how you feel, then you let her know. You love her, then let her know. (Sally still averts eye contact with her head down and her hands and hair covering her face.)

This sequence is facilitated by many key components. The mother's affect/intention remained productive, as did the content. The therapist nurtured this mood and discussion. If Marina were to get off track, the therapist would reenter the conversation and help her return to this effective posture. Family members often need more coaching during these early change attempts.

With Marina doing some excellent work, the therapist turns to Sally. In a sequence such as this one, therapists are taught to have an active mind and to listen to the conversation in an anticipatory way. On this occasion, several questions might occupy one's thoughts.

> What will it take for the daughter to respond at the same level as the mother?
>
> Has enough groundwork been laid with the daughter individually?
>
> Does the daughter believe that her mother really wants to hear what she might have to say?
>
> To what degree should the therapist encourage the daughter to express herself (versus involving the mother in the encouragement)?
>
> What are some reasonable outcomes for this sequence on this occasion? And, is it not possible that asking Sally to respond in this session may be reaching too far at this time?

Questions such as these inform a clinician's judgment on a moment-to-moment basis. How to recalibrate one's interventions in the action of a session is one of the most complex of all therapy skills.

Although Sally had shared in individual sessions ideas about what she wanted in a new relationship with her mother, as well as her feelings of abandonment by her mother, Sally did not discuss these issues with Marina in this interview, despite the therapist's urgings.

Given these circumstances, the therapist concluded that this sequence had progressed as far as it could on this occasion. Here we are careful to check ourselves for what might be called *in-session reductionism*. This is a malady of clinicians, common among structural therapists of bygone eras, which assumes that the only locale of change is within the session.[17] A related form of this disorder is *in-session reductionism—overdramatic type*, which proffers unrealistic expectations for the outcome of any particular sequence one facilitates. The genesis of this disorder is commonly believed to be the beloved, but sometimes dangerous, *edited training videotape*.

We were satisfied with the outcome of this session. The mother's stance toward Sally remained emotionally available and nonblaming. The daughter made it clear that she was touched by the mom's sincere efforts. Said Sally, "I don't want you [mother] to feel that way," in response to mother wondering whether or not her daughter cared about her. And in response to the therapist's question, "Why don't you want her to feel that way?" Sally responded, "Because I love her."

In this final sequence, sensing that there is a long way to go in furthering the kind of process that had occurred in this session, and realizing too that there were still some loose ends about what was discussed, the therapist worked to construct a useful ending to the session.

T: I don't think that we can have a sense of closure tonight on this topic. This is a huge and very important topic, but what I want to know is (to mom), is there anything that you can get . . . that you need from Sally right now, before you leave this room? Because, Marina, I have to say that I was very, very moved, as I think everybody in this room was. I know what you said was very hard, and you said a lot of things, and I was very, very moved. And I think that you certainly deserve some support, and I'm wondering if there's anything that you need from Sally before you leave this room tonight.

M: (pauses, then in a tender voice) I'd kind of like a hug. (then, with more firmness) I want a hug! (Mom and daughter reach out simultaneously and embrace one another—both sobbing. The therapist then ends the session.)

In this session the supervisor and therapist sometimes tried too hard to engineer the Big Bang—the breakthrough event that comes every so often in therapy. Further, we also realized that we had preconceptions about what this process would look like. Such expectations can create problems. On this occasion, these expectations almost helped us not to notice the change that was happening. This sequence reminds us that each participant in the conversation does not participate in the same way or at the same pace, nor is it important for them to do so. In this example, Marina recovered some of her positive motivation after the therapist's attention to her relationship with Marina. Further, Marina extended herself to Sally in an emotionally touching way. On this night, Sally did not respond as some of our other teenagers had. Still, in her own style and to the degree that she was able and willing in this session, Sally did indeed respond to her mother, and Marina recognized and appreciated her degree of response. A sequence of this nature also reminds us of the challenge to implement the multidimensional philosophy. That is, an overemphasis on emotional expression can miss cognitive or behavioral possibilities.

Finally, this sequence presents an opportunity again to remember the focus in this approach on an *incremental* or successive approximations view of change. This is our emphasis despite the fact that change can be defined as having both continuous and discontinuous elements (Liddle, 1982). We focus on working and framing change for family members as a series of small steps. These are defined by Mahrer (1988b) as "good moments" of therapy (i.e., processes that are instrumental to change). As Greenberg and Pinsof (1986) have put it, outcome should be broken down into the small *o*'s (small outcomes) that comprise a ground level view of the therapy process. Fixation on the final product, the Big *O* of a final outcome or a Big Event, can instigate unrealistic expectations and a focus at the wrong level of detail. Attention to these Big *O*'s would be like trying to hit a home run every time up at bat.[18]

Case 3: Apology and Forgiveness as Facilitators of Development

The previous case illustrated a flexible therapeutic stance that constantly assesses progress and shifts to different dimensions of human functioning and intervention as needed. It highlighted how to deal with commonly occurring circumstances that stop progress in the problem-solving realm.

This case explores another dimension of parent-adolescent relationship problems. It concerns the process of retribution, or, as the adolescent would sometimes call it, "payback," to the parent. In a payback scenario, the teenager feels that she or he has gotten a bad deal in the family and wants to repay the parent for her or his misery. As with all themes, this one is shaped both by the therapist and the family. The payback theme is not the only background process that inhibits normal developmental transitions. It is simply one of several potentially useful themes. Nonetheless, because of its affective power, this theme is one that we attended to quite carefully.

Although understandable from the viewpoint of the family's history, the payback process deters the adolescent's and parents' development. It derails the necessary negotiation of the teenager-parent relationship, making it difficult to deal with anything but issues relating to the payback scenario. Challenging the adolescent quite directly on this issue, the therapist might say, "You need to talk to your father and mother in new ways. It should be done in a way in which they can respond. The payback mode only feels good because you feel hurt. You know it won't help in the long run."

Some family therapists, especially those with a strategic orientation (Jurich, 1990) seem unnecessarily reluctant to challenge adolescents this explicitly. Developmentally speaking, we confirm the adolescent's attempts at self-definition, expression, and assertion, yet urge and teach new ways of accomplishing these. As we know, however, although preparation of the teenager is important, and the steps to ready the adolescent for more productive interchanges with his or her parent(s) are capable of specification, the results of clearly articulated plans do not always coincide with therapist intentions.

The following case illustrates successful interchanges between a mother and daughter. Although we have largely discussed the benefits of this kind of healing conversation for the adolescent, these processes can have profound impact on the parents as well. One aspect of this change process involves the rekindling of the parents' commitment to their teenager. More basically, conversations in this realm can help parents realize their *continued* importance in their child's socialization process. Changes

made by parents in this regard also give adolescents some needed hope that their parents can indeed change in outlook and behavior.

Roni is a 16-year-old who dropped out of school at age 13. At the start of therapy, she had just ended 10 straight days of "speed bingeing" (amphetamines) and had been staying with her 19-year-old drug-dealer boyfriend. She had recently been hospitalized for her second suicide attempt. Roni lived with her mother, Jan, a recovering alcoholic, for the last six years.

The following segments all come from the third session. Roni wore dark glasses, long black gloves, a black shirt and skirt, and long black leather boots. As this sequence begins, the therapist is presenting an aspect that might be possible in therapy.

"Will You Let Your Mom Know You?"

Therapist: Roni, you said something very important. You said to your mom, "You don't really know who I am so you cannot really say anything about me." And that's part of who you are. You keep yourself very private. But I hear Jan (mom) saying that she would like to know you a little bit more (Roni starts to shake her head, saying "no" with this gesture)—things like what you are thinking and feeling. Could we use some of this time in therapy for letting her get to know *you,* the real *you?*

Roni: Every time—No. I'm so . . . I don't want anybody to know me, because when they know me, they know how to hurt me, and when they know that, they do it and it hurts.

T: And that's happened to you before?

R: Many, many, many times. Countless times. And I've finally gotten to this point that I've been striving for for years, where *nobody* knows me. Nobody can! Nobody can barely even look at me in the eye anymore. I wear my sunglasses constantly because I believe—and I don't know if you guys are gonna think I'm crazy but—I believe the eyes are the doorway to the soul and that when you really look into somebody's eyes dead on without anything in between, there's like a connection. And then you really know somebody. And because of that, I always wear my sunglasses.

T: Are you afraid your mom might hurt you?

R: Uh-huh. She has in the past.

T: She has in the past?

R: Very much so!

The therapist helps Roni to explain her emotional world and her drastic coping strategies. Roni protects herself from further hurt with her sunglasses and long black gloves. Later, Roni explained that her persistent involvement in the drug culture was related to a profound unhappiness with her life. Roni had made two serious suicide attempts. Despite her negating the possibility of trying new ways of involvement with her mother, Roni's openness gave us some hope. In assessing Jan's contribution to the current stalemate, we wondered whether she could respond to the frank discussions that the daughter seemed able to instigate.

Problems in Problem Solving As we have said, part of this model involves straightforward problem solving. Everyday life problems comprise the content of these discussions. Parents are supported to discuss age-appropriate expectations of their adolescent, and teenagers are helped to negotiate with their parents. However, when working with adolescents and parents whose past together has been tumultuous over a period of time (e.g., neglect, abuse, alcoholism and drug abuse of parents or other significant adults), problem-solving or skill-training approaches in the usual sense can have their limitations. That is, although this remains an empirical question, it was our clinical impression that the problem solving could not be about the day-to-day problems but about these fundamental relationship breaks and transgressions, some of which have been active for 10 or 15 years. Thus, the content of the problem solving was critical to its success.

Attention to and work in the parents' and adolescent's affective realm were a matter of course in our work. Although this focus might be seen by some as a return to age-old, hydraulic thinking (i.e., penetration to deeper levels of awareness as key to therapeutic unlocking resistances), work in this realm can motivate and provide an effective *foundation* for problem solving and skill training. Enactment is also conceived as a multistaged procedure. As we have said, the whole-part metaphor helps the therapist to remember that facilitating effective communication and problem solving does not only occur in therapist-guided parent-adolescent enactments.

In the final case, attempts at straightforward problem solving yielded generally limited results. The dilemma was framed: What alternatives exist when one's best efforts at facilitating a problem-solving sequence have met with only limited success? A multidimensional approach suggests a variety of alternatives may produce equally positive results. In the final case, motivational issues were considered primary. The therapeutic problem became how we could materialize the reasons *why* mother and daughter should want to be in a position of negotiation and dialogue with each other. In these situations, MDFT relies on a "first-things-first" philosophy.

At an impasse, the therapist asks, "What might be the *next* thing that has to happen for progress (e.g., a reasonable conversation on realistic content) to be made?" We realize, of course, that there might be many "next" things that need to occur, and hence it would be a problem to search for the one correct key to break a stalemate. Again, change, at least the "change" that therapists can have most immediate access to, is viewed in terms of successive approximations.[19]

With Jan and her daughter, our judgment became: Something else had to happen before mother and daughter could negotiate and problem

solve. Our therapists were advised to keep in mind some guiding questions to orient and track their work. A central question in this case (which was also a generic question used with other cases was: *What is the missing event (conversation, statement, condition) or pattern (the interactional dimension of the missing event) that could move this process along?*[20]

In this case, both Jan and Roni had legitimate claims against each other, and neither was able or interested in helping the other solve their shared problems. Indeed, in a typical scenario such as this one, problems are *not* seen as shared (as ours) but as residing within the other (as "your problem"). The transformation of this attribution is a primary task of family therapy, even though it is not frequently cast in this way.[21] With Jan and Roni, themes of rejection and retaliation permeated their interactions. Movement toward reconciliation, as we have said, is not a simple task. Problem-solving attempts often become mired in the adolescent's retribution and in parental resignation.[22]

Given these conditions, family therapists in the Adolescents and Families Project were trained[23] to facilitate in-session shifts as solutions to in-session stuck points. These were shifts of focus, of domain of operation, and of content in a session. We look to different levels of meaning or different domains of communication for a way out. Overriding questions in these circumstances become:

> Am I focusing on the useful content?
> Is this conversation at an appropriate level of detail?
> Is the territory in which this session is now operating on target?

These kinds of questions are asked of oneself during the session. They help develop an intentionality and criterion-driven methodology for moment-to-moment decisions. The following segments exemplify an intentional shift of domain of operation in the session, and were achieved through a process like the one we have just described.

"What's Getting in the Way Here?"

R: (angrily) You think that I'm really irresponsible, and I can't do shit.

Mom: (curtly) That's not true.

R: Yes, it is.

M: No, it's not. (The negative tone continues, and perhaps is escalating.)

T: (leans forward, trying to cut the sequence and get each person's attention) Is that really why you're so mad? Is that really the core of all this? I think you're just talking about the superficial stuff. I don't think that's where it's at. I want to know what makes this so hard. What's getting in the way of you two working out day-to-day problems? Why is there so much anger and resentment?

R: The list could go on and on and on of the things that she's done to me.

T: Think of the worst things.

This meaningful interchange puts the problem-solving quest into a new light. By amplifying the discussion to include the affective realm, which in this situation includes past resentments and hurts, the therapist creates a shift in the interview. The tone changes dramatically as possibilities for discussing core affective themes (e.g., forgiveness) appear. Although no single intervention exists to tap the territory of relational expectations and regrets, focus and persistence are extremely helpful. We ask each family member, repeatedly if necessary: Why is this so hard? What's getting in the way? The goal is to help each family member define for himself or herself, sometimes alone and other times in the presence of others, what each perceives to be the barriers to progress. Leading a family to explore and create a new story about a significant trauma can be risky, difficult, and upsetting for all those in the room, including the therapist. Work in this realm of strong emotion requires a clinician's compassion and commitment to enable each family member to address the fundamental issues. In the acting profession, there is a saying having to do with "getting at the truth" of a scene or character. Effective family therapy with teenagers and their parents gets at the truth or the essence of these tormented relationships—family ties that have been stretched to the breaking point.

In the next segment, the theme of forgiveness has been reintroduced into the discussion. It had been developed previously as a necessary theme and goal.

T: Roni, what's the part that hurts the most? What's the part that you have the most difficulty forgiving her for?

R: Abandoning me. She abandoned me.

T: How did she do it? How did she abandon you?

R: (fidgeting with her hair, continuing to cry) We were a family once a long time ago. We were a family! I had my friends over and I had little birthday parties and slumber parties and . . . (starts to cry).

T: What happened?

R: Mom decided she can't stand our town and wants to move to the big city. As soon as we get here, it's like all of a sudden she wasn't mommy. She moved here all by herself with her two kids on welfare and she just got all these strokes for it. Everybody said, "Oh Jan, oh Jan, honey, honey (mockingly pats mother on the back), I'm so proud of you. I can't believe you did this all by yourself." And she got so caught up in this, it was like I didn't even exist anymore.

T: Say more, Roni.

R: I mean, I would ask, "Can I go out, Mommy?" "Sure, go ahead, have fun." While she's sitting there, with all her friends getting all these strokes.

T: So, she didn't do all that she's trying to do now.

R: She didn't do anything!

T: Is she trying now to be the mother she wasn't for all those years?

R: Maybe. But it's too late now. I don't want it! I won't take it! It's like saying, "Oh, I'm so sorry, honey, I didn't give you a Christmas gift for the past 50 years but that's okay, I'll give you a toy car now to make up for the one I didn't give you when you were six." Well, it doesn't work like that.

T: So you're saying she'll never be able to make up for all the lost time and all that she hasn't given and what she took away.

R: I'm not saying that. I'm saying that she can't start treating me like I'm 12 now just because she didn't treat me like I was 12 then.

This segment reveals principal aspects of the healing conversations we attempt to promote. Important relationship issues have become articulated. Roni's longing for the parenting her mother once provided ("we were a family a long time ago"), her ability to define the problem in her own words ("you were too into your own thing to pay attention to me"), and a beginning specification of the conditions under which change could occur (e.g., there are some ways in which mother cannot make up for the past and an implication that there are some ways in which she can). Revelations are not the goal. Articulation of this content serves to form the arena within which the next conversations will occur. Progress with Roni, however, is half the battle, since it is equally important to develop mother's views on this same topic.

Helping the Adolescent Take Responsibility Sessions may have extensive discussions of past events. However, getting history on the table of therapy merely begins the necessary therapeutic process. As past events loosen their grip, other themes gain salience. Although the events themselves are in the past, the feelings and thoughts about them often remain as vibrant as ever.

Discussions regarding each person's responsibility for present behaviors and commitments to future actions are also important components of the therapeutic fabric. The segment below shows how the therapist confronted Roni's use of her past hurts for current purposes.

T: Why is coming home on weeknights unreasonable?

R: Because I work on Friday and Saturday day, which means I cannot go out on Friday and Saturday nights or else I'll be too tired to work. I'm off on Tuesdays and Thursdays, which means my nights out should be Mondays and Wednesdays.

T: Are you saying that you're willing to live in the house if your mother is more reasonable?

R: It depends on how reasonable is reasonable.

T: See, Roni, I think you're teasing her. You're being unfair to her in a very basic way. On some occasions, you'll say, "Mom, I'm your daughter and, yeah, we'll dance like it's a mother and daughter thing and we'll talk about negotiation, and about when I come home and when I stay out, and all of that." But there's a certain point in that discussion where you say, "No more," where you say, "No, I've just changed the rules on you. *Now* we are just going to be friends." And that's not a good scene, Roni. That's no good.

R: Well it gets to a certain point where I can't take it any more.

T: I understand that. But I think you have the capacity to deal very directly with your mom about things that are upsetting you. But because you are so smart, you keep changing the rules. In addition to making her squirm and kicking her, it creates constant instability for the two of you. She's your mom for that three minutes and then for the next two, you're just gonna be friends. You say she comes on harsh to you, but you're making her crazy. Anybody would feel crazy.

Here, the therapist introduced a number of themes that will be developed throughout treatment. First, Roni's protective strategies are understood as part of her contribution to the present difficulty. This challenge, and its correlates to be developed later, encourage Roni to seek developmentally appropriate alternatives to her current conflict resolution tactics. Roni is invited to transform her victimized, powerless position and replace it with an increased sense of agency.

The adolescents are challenged, as we put it, for revoking their mother's or father's "parenting license." They are told, as in this sequence, that although their complaints may have some validity and should be responded to by the parent, the manner in which they express their concerns is ineffective. The therapeutic relationship and the context of therapy are offered as forums where they can be assisted in expanding their repertoire of expression and action.

Finally, the challenge in the previous sequence lends some needed support to Jan. If Roni's perspective was to become the sole focus of the treatment, the mother would clearly question the goals of the therapy (indeed, this would be a sure sign of a therapy badly out of balance). Multiple alliances and appropriately complex themes must always be developed in this work.

This support for Jan might be related to how she moves into an emotionally open position with her daughter in the following "confessional" dialogue. Mother is moved by Roni's revelations. It prompts similar behavior from her.

Affirmation Fights Abdication

Roni is looking down with her head in her hands.

M: (to Roni) I'm certainly open for discussions about whatever it is you feel you need to explore. Even if it means in the larger sense of our relationship. Because I think it's more than you staying out on weeknights. I think it's *way* more than that.

This is significant since it implies that mother realizes the importance of having a conversation at the right level of detail and content.

T: What do you mean? What do you think it is?

M: I think it goes deeper than that.

T: Well, say what you think.

M: I think she's pissed off at my leaving her father and leaving that family unit—the traditional family unit. We were in a middle-class, all-American family situation and I left that, ended up on welfare, you know, and the list goes on and on from that.

T: Right. What else?

Roni continues. Crying, she confronts the mother with the fact that while mom was drunk, the son of mother's best friend sexually abused Roni. Jan admits she was intoxicated at the time but, at the same time, she shows a willingness to discuss this incident with her daughter. The therapist probes to see if there are other issues or events between them that should be explored. Jan replies.

M: Well, there was my drunkenness, my drug use, my open relationship attitude. I think my boundaryless relationships affected a lot of people, including my children, and I think that's *really* done some incredible damage.

Jan gives a powerful acknowledgment of her daughter's reality for the past dozen years. Further, Jan discussed her need to gain more skills ("Yes, maybe I do need more skills, that's why I'm here") and to be more consistent in her parenting. Roni was attentive during her mother's discussion of these important matters. Conversations that acknowledge hurts and involve new, openly-stated levels of responsibility taking promote healing of torn parent-adolescent relationships. Although they are certainly not the only means through which such healing can occur, they are prime examples of the kind of therapeutic events we seek to sponsor.

Setting the Agenda for Future Sessions Content themes are established and constantly revised and reworked throughout therapy. The following segment shows how closure is brought to the session. The interview's content is identified as central themes for future work. This procedure, importantly, links the therapy over time. In this case, this content became the starting point for the next session. Not uncommonly, these themes attained greater richness and complexity as they were discussed in each following session.

T: So, Roni, is there no forgiveness forthcoming? (pause) Would you be willing, Roni, to talk with us about what forgiveness is—what it means to you?

R: I could try but I don't really even know what forgiveness is, I don't forgive

people. I'm there and I love them and I'm loyal to them until they fuck me over, and then after they fuck me over, they don't exist.

T: And that's what we have here. Okay—that's what I mean. So you *do* have a sense of what is in the way here. That is good. I'd like to suggest this. (Hesitating, and momentarily incapacitated by Roni's extreme stance about forgiveness and not exactly sure how to create an opening for future work in this area, the therapist wonders: "Has Roni closed this theme off from work?") (Now talking to both mother and daughter, the therapist decides to let them in on his thinking about how this theme can guide their work together.) In the normal course of events, we would be discussing things like pragmatics and logistics—day-to-day problem-solving things. But, obviously, there's so much stuff that exists between the two of you that these discussions would not be fruitful. What we need before any problem solving gets done is to decide what discussions need to occur between the two of you. What's the stuff that's still in the way of achieving progress on pragmatics, such as decisions about where Roni's going to live, where she's not going to live, and so on? And, I think two of the areas we've got to get to are the two I've mentioned. One is, what will it take for Roni to offer some *forgiveness* to her mom? And the other is, how can Jan begin to prove herself as more *believable* to her daughter? Forgiveness and believability are the two themes.

Roni, like many of the teenagers we have seen, did not believe that life with her family might have some value to her. Over the years, Jan's inconsistent availability and ineffective protection left Roni with, at best, ambivalent feelings toward her mother. We were often reminded of Patterson and colleagues' work on parental monitoring as a critical aspect of a healthy family environment (Dishion, Patterson, & Reid, 1988; Patterson, Dishion & Bank, in press). Roni's search for independence and identity did not evolve from a secure base (Bowlby, 1988). She seemed to be running from the chaos and unpredictability of her youth. The therapist established order to the therapy by naming some benchmarks by which progress could be measured. In this case, Roni was challenged about what we called the "kicking quota" (a retribution system) in which she seemed to operate. We asked her when would she be done "kicking" or paying back her mom? Was there no end to it or could it be altered by building in new ways of relating in the present? As we have said, these behaviors are challenged quite directly. A pragmatically useful and hope-inducing assumption, stated explicitly to the adolescent and parent, is that the adolescent can do better at communicating and negotiating the parent-adolescent transition.

Achieving these transitions (e.g., decreased hierarchy of the parent-adolescent relationship and age-appropriate connectedness) are hindered by many things, including carried-over issues from the family's past together. Mother's responsiveness, which we facilitated and amplified in individual sessions, was certainly vital to our success in this domain. Roni's newfound abilities (e.g., to think complexly about and manage some degree of forgive-

ness), which were also accessed and accentuated by work with her alone, were equally important to the advancement of a new process between mother and daughter.

Conclusion

Although the family therapy approach, developed in the Adolescents and Families Project, both in name and in practice is multidimensional, this chapter, by design, has focused on a selected number of dimensions (e.g., the adolescent, the affective realm). Nevertheless, we hope that the basic thrust of the multidimensional approach has been visible. Existing in the contemporary movement of integrative therapeutic models that construct comprehensive, specialized treatment manuals for particular problems and populations, Multidimensional Family Therapy (MDFT) operates in several domains simultaneously:

1. MDFT considers *multiple realms of human functioning* and *targets of intervention* (e.g., affective, cognitive, motivational, behavioral).
2. MDFT has *multiple foci of the interventions* (e.g., adolescents, parents, adolescent-parent interaction, whole family, extrafamilial).
3. MDFT has *multiple content themes of therapy* (e.g., substance abuse, past hurts and disappointments, ineffective parenting styles, difficulties in renegotiating parent-adolescent transition, individual skill deficits, as well as those in adolescent-parent communication, abdication of parental responsibility).
4. MDFT uses *multiple types of interventions* (e.g., in-session and out-of-session problem solving, understanding and reworking the past, reformulation of cognitive attributions, facilitation of forgiveness, resuscitation of parental devotion and love).

Although the approach is multidimensional and integrative, it is not an unsystematic potpourri of interventions (quite to the contrary, since it aims to be systematic and specialized). It is systematic in that the model consists of a protocol for working among the multiple dimensions outlined earlier. It is specialized in that this protocol has been developed specifically for substance-abusing and conduct-disorder adolescents and their families and not as a general model of family therapy. The major benefits of such a model are that it is tailored to the particular problems and needs of adolescents and their families, it can be scientifically evaluated, and it can be readily disseminated.

Walking the Tightrope Can we identify a process that exemplifies the difficult work of family therapy with adolescents and their parents? When working with adolescents and their families, clinicians must learn how to walk the tightrope. They must establish and maintain alliances with both the adolescent and the parents; hence, at one time they must be the voice of the adolescent, at other times they serve the same role with the parent(s). To support and speak for both parents and teenagers while also taking into account extrafamilial systems such as juvenile justice and school is a daunting task. Yet, maintaining multiple alliances is not only possible but essential to successful therapy with drug-abusing adolescents and their families.

Since this chapter focuses primarily on the adolescent side of the equation, we will summarize certain basic principles of working with the adolescent.

Our initial challenge is how to engage adolescents in the therapy. The majority of substance-abusing adolescents will come to therapy only because either their parents or the juvenile justice system has ordered them to do so. Since we have found that active participation by the teenager in the therapeutic process increases chances for success, it is vital to help the adolescent formulate a personal therapeutic agenda. Without this viable agenda, engagement will be compromised.

Establishing the adolescent's agenda is one of the primary and first therapeutic challenges. The adolescent must be convinced that therapy can be worthwhile for him or her personally. To accomplish this goal, the therapist must show the teenager, through both words and actions, that therapy will be more than just helping the parents to be more powerful and controlling. Engagement and alliance-building strategies are continued throughout the therapy. Examples of adolescent engagement and agenda-setting strategies were most clearly seen in the treatment excerpts of Sam and his family.

As mentioned in the introduction, MDFT tries to facilitate both in-session and out-of-session change. Fostering in-session change through enactment, as can be seen in the excerpts, is a core component of this approach. We are very careful to adequately prepare the adolescent, the parent(s), and other family members for these conversations. This step maximizes possibilities for success. Preparation consists of meeting with each family member alone to explore, highlight, question, and acknowledge personal beliefs, attitudes, opinions, and feelings about self, other family members, and the family as a whole. We try to help each family member figure out how he or she feels and what he or she thinks about important content themes that either the therapist or family member has brought to the therapy.

By working individually with each family member before the enactment, the therapist is able to (1) solidify alliances so that the therapist will be free to challenge in the upcoming enactment sequence, (2) help each family member formulate the content and style of what he or she wants to say to other members, and (3) elicit from each member his or her most

helpful statements. The definition of *helpful statements,* of course, will vary from family to family, person to person, and issue to issue. An example of a helpful statement would be a parent's stated willingness to listen to his or her adolescent's perspective despite many previous disappointments and hurts. Preparation of this sort was illustrated in segments from the last case of Roni and her mother, Jan.

Many substance-abusing adolescents feel that they have little control of their emotions, thoughts, behaviors, and daily life. Although they may not be able to articulate precisely how they experience the world, many adolescents have an unmistakable sense that something in their life is desperately wrong. Several interventions are used to alter this experience. First, we have high expectations for the adolescent, and we attempt to increase his or her own self-expectations by providing alternatives—holding up certain desirable behaviors and in essence saying, "This is what you can do, this is what you can be, this is how you can get along in the world, and this is how you can interact with your parents." For each family we may use different materials to sketch this portrait of higher expectations (e.g., attributions, emotions, the past, etc.), but the message is always the same: You can do better *and* I'm going to help you do better.

We also present to the adolescents our high expectations of their parents. We tell the teenagers about our goal of helping their parents be better parents—to be more fair, to listen and acknowledge them, and to be more responsive. By talking to the adolescents about their parents' parenting, we counter the teenagers' realization that responsibility for change does not lie solely with them. This serves to counter some of their pessimism as well. It can be a difficult balance to maintain, but we want adolescents to feel *some degree* of responsibility to help alter their parents' behavior, but not too much responsibility. The therapist creates a partnership with the teenager that, among other things, helps deal with parents and about how those parents treat the teenager. Adolescents appreciate having and often need a spokesperson, even one that is not always completely on their side. They are accustomed to a world that does not respect them, expects them to be unreasonable, and, in general, understands adolescence (incorrectly so) as a time of necessary storm and stress (Offer, Ostrov, & Howard, 1981).

In addition to increasing expectations, we help the adolescent, literally and figuratively, find a different language, and thus a different way of being in the world. With our initial case in this chapter, the therapist tried to help Sam communicate his unhappiness and frustration through words rather than through violence and self-destructive actions. With Roni, the therapist helped her talk to her mother about past hurts and betrayals rather than continuing to indirectly punish her mother by severe drug use and suicide attempts. With Sally, the therapist helped her to begin communicating how much she cared for and loved her mother. The language that we

aim for is one in which the adolescents can, to the best of their ability, explain their subjective experiences, world views, hopes and dreams, complaints and disappointments. Again, although not discussed in this chapter, it is important to remember that we also work just as intensely with the parents so they will be receptive to their adolescent's new language.

Coda

By virtue of its built-in comprehensiveness, flexibility, and specificity, multidimensional therapy offers therapists and families the necessary tools for repairing family functioning and, as a result, reducing or eliminating the adolescent's self-destructive behaviors such as drug abuse, suicide attempts, school failure, and violence. We aim to mend these relationships by establishing and maintaining strong alliances, by raising expectations for the self and other family members, by preparing family members to have conversations on topics that relate to core family themes, by helping family members to engage in effective in-session and out-of-session problem solving and negotiation, and by assisting them to practice new behaviors and accommodate when necessary to the changes of others. These are the necessary concomitants of change.

In AFP's families, the adolescent-parent(s) relationship is in severe disrepair. These are families full of misunderstandings, hurts, disappointments, hopelessness, and betrayals. Living in a land of extremes of thought and action, these individuals, understandably, come to devalue family relationships. These intense feelings and processes must be dealt with in a forthright manner. Starkly stated, the families seem to experience their lives as their own private hell. It is the therapist's job to venture into this ominous territory with courage, conviction, compassion, and, of course, great skill. The families need and deserve no less.

Endnotes

1. NIH Guide for Grants and Contracts; Volume 12, Number 8, August 19, 1983—National Institute on Drug Abuse Program Announcement titled "Family Therapy and Prevention Research."

2. The Adolescents and Families Project began in 1985 at the University of California, San Francisco, and moved for its final year of operation to Temple University in April of 1990.

3. Although not without its critics (Stanton, 1988), the treatment manual tradition that is currently flourishing in the psychotherapy research world (Lambert & Ogles, 1988) has been a source of inspiration and guidance in the development of multidimensional family therapy (MFT). For instance, Kaufman (1985) has supported the development of treatment manuals that would be accompanied by intensive training and supervision for the family therapy of drug abuse. The family therapists in the Adolescents and Families Project were trained in the MFT ap-

proach prior to seeing cases and were supervised via live supervision throughout the research project.

4. Although Todd (1990) has stated that the MFT model used in the Adolescents and Families Project was based on and was a test of the Stanton and Todd (1982) structural-strategic approach, this is not the case. Liddle's (1984, 1985) initial version of structural-strategic therapy was much more clearly related to the structural-strategic approaches of Stanton (1981) and Todd (1986) than is MDFT. The approach developed for the Adolescents and Families Project, for instance, does not use paradoxical interventions, does not employ a function of the symptom concept, does not primarily draw from other schools of family therapy for its tenets and methods, is not ahistorical in its focus, uses adolescent development research to guide its assessments and interventions, and works with individuals in the course of treatment more than the structural-strategic models. It should be noted, however, that Stanton's own work has evolved and recent publications seem to take remove him from the structural-strategic realm (Stanton, 1984). Todd's (Todd & Selekman, 1990a) more recent work seems to have changed less than Stanton's relative to the original Stanton and Todd (1982) model. Todd integrates aspects of other brief family therapy models (e.g., the DeShazer, White, and Milan systemic model) into the basic structural-strategic (Stanton & Todd, 1982) model.

5. Other components of MDFT include work with other individuals (each parent alone, the teenager's friends), other subsystems (parental and sibling), and extrafamilial systems (school and probation personnel). The skills and special problems associated with these components are the subject of other publications.

6. With this said, we must heed the caution issued by Lazarus, Coyne, and Folkman (1982) on the topic of apparently neat classifications and distinctions between these realms of human existence: "Thoughts, emotions, and motives are inferred from observations of the person . . . how we partition these concepts and punctuate theoretical sequences is often a matter of theoretical and methodological convenience" (p. 232). While realizing the usefulness of separating these domains of existence and experience, Folkman, Schaefer, and Lazarus (1979) have argued for an understanding of the realms and acknowledging their constant interplay.

7. Although this is not a specific reference to the multimodal therapy of Arnold Lazarus, his model should be recognized as one of the best contemporary examples of integrative theorizing and therapy model construction.

8. Family reductionism commits the same conceptual error that family therapy was invoked to alter. Reductionism at the level of the family places the onus for health and pathology at the doorstep of the family, ignoring other relevant systems of influence. Family therapy's rediscovery of the individual is, to adapt a concept from modern-day economic theory, part of a *conceptual "correction."*

9. The concept of the therapeutic alliance in family therapy remains, as yet, underdeveloped. Pinsof and Catherall (1986) provide an example of the kind of work needed in the family systems field that appreciates the tradition, conceptual developments, and research on therapeutic alliance in the individual psychotherapy field, and builds concepts and research methods for use in family therapy.

10. Subsystem therapy is used to portray an approach that does not only work with the entire family unit. Separate sessions with the key subsystems, the adolescent (which sometimes includes siblings and peers) and the parent(s), are fundamental to this model. Although family therapy models moved in a reductionistic direction, some of the field's most prominent approaches (e.g., Bowen, Brief Therapy Model, Milton Erickson) regularly see individuals alone.

11. This chapter emphasizes the skills of doing a multidimensional, multisystemic therapy through the adolescent subsystem. This is not meant to imply that the skills needed to work for adolescent, parent, and family change through the parental subsystem are somehow less vital. The modules for working such subsystems as the parental and extrafamilial subsystems are developed in other publications. Important themes in the parental subsystem, for example, have included the establishment or rekindling of parental hopes, dreams, and aspirations for their adolescent. This revitalization of a parent's commitment, which could be said to address the so-called parental imperative, can be accomplished through interventions that promote compassion, perspective taking, and a stance of negotiation on the parents' part. As one can see, this genre of intervention can serve as a necessary complement to the control and authority-oriented interventions commonly thought of in work with the parents of teenagers.

12. Howard Liddle was the coordinator of the family therapy condition on the project. He supervised cases using live and videotape methods.

13. *Understand* and *confirm* perhaps do not carry enough of the connotation of how these realities are both understood/confirmed *and* shaped, simultaneously. At this stage of therapy, however, given the developing therapeutic alliance between therapist and teenager, it is probably more accurate to say that we aim for a more "pure" understanding and confirmation of the reality of the adolescent's life as he or she experiences it.

14. One of the most difficult challenges for any therapist concerns how to do therapy with a consistency of themes (which, of course, develop and evolve over the course of therapy), while at the same time maintain the ability to incorporate new content into these themes. This new content often serves as a major factor in the themes' transformation.

15. Although *modeling* certainly is a factor in a change process of this nature, our conception of change centers more on the work that occurs in the therapeutic relationship between therapist and adolescent, and on the changes that are practiced outside of the therapy session, rather than on a modeling theory per se.

16. Just as the concept of the therapeutic alliance is still in formation in family therapy, the notion of splits or ruptures in the therapeutic alliance (Safran et al., 1990) await conceptual and empirical inquiry.

17. A related but converse disorder, of course, is *out-of-session reductionism,* in which it is assumed that change happens outside of sessions, primarily as a result of a therapist's directives.

18. Extending the metaphor, although it is easy to think of affective breakthroughs as "home runs," other, less dramatic moments and events in therapy can have more solid, long-lasting consequences. Cognitive understanding, downplayed by such theorists as Haley (1976), can serve as a powerful foundation for, or post hoc organizer of, behavioral change. In general, family therapy has, unfortunately, not appreciated the role of individual differences on these dimensions in the change process.

19. The version of change that is referred to as *discontinuous* (Hoffman's "leap theory" of change) seems, at least according to the way we do therapy, as more out of reach and ephemeral in the clinical realm. It seems to promote a magical thinking rather than a hands-on, "what is the next step in the change process?" attitude on the therapist's part.

20. The language here clearly avoids the connotation of the question: What needs to happen for things *to be solved?* There is rarely such finality and surety in

human interaction and problem solving. The intent is to create a system of expectation with the families that problems are not "cured" by therapy; they may indeed arise again. The difference would be that they have new ways of looking at and skills for solving the life events and problems that will come their way.

21. The cognitive revolution that has swept psychology has been slow, thus far at least, to take hold in family therapy. Its impact in family psychology and marital and family studies, however, has been marked (e.g., Epstein & Baucom, 1988; Finchman & Bradbury, 1988).

22. Taking our cue from the process research literature and its methodology, we have begun to identify the specific markers that evidence poor problem solving in parent-adolescent communication (and hence the need to change focus) (Diamond, 1990).

23. The best representation of the family therapy training philosophy used in AFP can be found in Liddle (1988a, 1988b).

References

Aber, J. L., Allen, J., Carlson, V., & Cicchetti, D. (1989). The effects of maltreatment on development during early childhood: Recent studies and their theoretical, clinical, and policy implications. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* New York: Cambridge University Press.

Achenbach, T. M. (1986). Developmental perspectives on psychotherapy and behavior change. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change.* New York: Wiley.

Achenbach, T. M. (1990). What is "developmental" about developmental psychopathology? In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Nuechterlein, & S. Weintraub (Eds), *Risk and protective factors in the development of psychopathology.* New York: Cambridge.

Alexander, B. K. (1990). The empirical and theoretical bases for an adaptive model of addiction. *The Journal of Drug Issues, 23,* 37-65.

Alexander, J. F., Klein, N. C., & Parsons, B. V. (1977). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45,* 469-474.

Alexander, J. F., Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81,* 219-225.

Avis, J. M., & Sprenkle, D. H. (1990). Outcome research on family therapy training: A substantive and methodological review. *Journal of Marital and Family Therapy, 16,* 241-264.

Bandura, A. (1978). The self system in reciprocal determinism. *American Psychologist, 33,* 334-355.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of functional family therapy: Three replications. *The American Journal of Family Therapy, 13,* 16-26.

Baucom, D. H., Epstein, N., Sayers, S., & Sher, T. G. (1989). The role of cognitions in marital relationships: Definitional, methodological, and conceptual issues. *Journal of Consulting and Clinical Psychology, 57,* 31-38.

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance abuse. *Journal of Early Adolescence, 11,* 56-95.

Baumrind, D., & Moselle, K. A. (1985). A developmental perspective on adolescent drug abuse. *Advances in Alcohol and Substance Abuse, 4,* 41-67.

Blechman, E. A. (1982). Conventional wisdom about familial contributions to substance abuse. *American Journal of Drug Alcohol Abuse, 9,* 35-53.

Blechman, E. A. (1990). The knowledge base of family therapy. Review of M. McGoldrick & B. Carter (Eds.), *The changing family life cycle: A framework for family therapy. Contemporary Psychology, 35,* 812.

Blos, P. (1979). *The adolescent passage.* New York: International Universities Press.

Bowlby, (1988). *A secure base.* New York: Basic Books.

Bronfenbrenner, U. (1979). *The ecology of human development.* Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1983). The context of development and the development of context. In R. M. Lerner (Ed.), *Developmental psychology: Historical and philosophical perspectives* (pp. 147-184). Hillsdale, NJ: Lawrence Erlbaum.

Brook, J. S., Brook, D. W., Gordon, A. S., & Whiteman, M. (1984). Identification with paternal attributes and its relationship to the son's personality and drug use. *Developmental Psychology, 20,* 1111-1119.

Brook, J. S., Brook, D. W., Lettieri, D. J., & Stimmel, B. (1985). Adolescent alcohol and substance use and abuse: A cause of concern or for complacency. *Alcohol and Substance Abuse in Adolescence, 4.*

Brook, J. S., Nomura, C., & Cohen, P. (1989). A network on influences on adolescent drug involvement: Neighborhood, school, peer, and family. *Genetic, Social and General Psychology Monographs, 115,* 123-145.

Brook, J. S., Whiteman, M., Gordon, A. S., & Brook, D. W. (1985). Father's influence on his daughter's marijuana use viewed in a mother and peer context. *Alcohol and Substance Abuse in Adolescence, 4,* 3-4.

Bry, G. H. (1983). Family-based approaches to reducing adolescent substance use: Theories, techniques and findings. NIDA Monograph 47.

Bukstein, O. G., Brent, D. A., & Kaminer, Y. (1989). Comorbidity of substance abuse and other psychiatric disorders among adolescents. *American Journal of Psychiatry, 146,* 1131-1141.

Burke, R. J., & Weir, T. (1978). Benefits to adolescents of informal helping relationships with their parents and peers. *Psychological Reports, 42,* 1175-1184.

Burke, R. J., & Weir, T. (1979). Helping responses of parents and peers and adolescent well being. *Journal of Psychology, 102,* 49-62.

Carnegie Council on Adolescent Development. (1989). *Turning points: Preparing American youth for the 21st century.* The report of the task force on education of young adolescents. New York: Carnegie Corporation.

Carter, B., & McGoldrick, M. (1986). *The changing family life cycle.* Boston: Allyn and Bacon.

Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98,* 388-400.

Cicchetti, D. (1984). The emergence of developmental psychopathology. *Child Development, 55,* 1-7.

Congressional Record—Senate. (1990). Using family therapy to treat adolescent drug abuse (H. Joanning, R. Lewis, & H. Liddle). May 1, 1990, S5506–S5507.
Coombs, R. (1988). *The family context of adolescent drug abuse.* New York: Haworth.
Cooper, C. R., Grotevant, H. D., & Condon, S. M. (1983). Individuality and connectedness in the family as a context for adolescent identity formation and role-taking skill. In H. D. Grotevant & C. R. Cooper (Eds.), *New directions for child development: Adolescent development in the family* (Vol. 22, pp. 43–59). San Francisco: Jossey-Bass.
Coyne, J. C., & Liddle, H. A. (in press). The future of systems therapies. *Psychotherapy.*
Daruna, J. H. (1990). Preventing substance abuse: Directions for action. Review of B. S. Brown & A. R. Mills (Eds.) (1987). *Youth at high risk for substance abuse.* ADAMHA Publication, Rockville, MD.
Davidge, A. M., & Forman, S. G. (1988). Psychological treatment of adolescent substance abusers: A review. *Children and Youth Review, 10,* 43–45.
Diamond, G. S. (1991). *Resolving a parent child conflict: A discovery oriented process study.* Presentation at American Association for Marriage and Family Therapy Annual Conference Research Institute, October 1991, Dallas, Texas.
Dishion, T. J., Loeber, R., Stuthamer-Loeber, M., & Patterson, G. R. (1984). Skill deficits and male adolescent delinquency. *Journal of Abnormal Child Psychology, 12,* 37–54.
Dishion, T. J., Patterson, G. R., & Reid, J. R. (1988). Parent and peer factors associated with drug sampling in early adolescence: Implication for treatment. In E. R. Rahdert & J. Garbowski (Eds.), *Adolescent drug abuse: Analyses of treatment research.* NIDA research monograph 77, 69–93.
Dishion, T. J., Reid, J. B., & Patterson, G. R. (1989). Empirical guidelines for a family intervention for adolescent drug use. In R. H. Coombs (Ed.), *The family context of adolescent drug use.* New York: Haworth.
Dryfoos, J. G. (1990). *Adolescents at risk: Prevalence and prevention.* New York: Oxford University Press.
Eisner, L., & Liddle, H. A. (1991). Myths of adolescence: What clinicians need to know. Submitted for publication.
Elliott, D. S., Huizinga, D., & Ageton, S. S. (1985). *Explaining delinquency and drug use.* Beverly Hills: Sage Publications.
Epstein, N., & Baucom, D. (1988). *Cognitive-behavioral therapy with couples.* New York: Brunner/Mazel.
Erikson, E. H. (1968). *Identity: Youth and crisis.* New York: Norton.
Erickson, G. D. (1988). Against the grain: Decentering family therapy. *Journal of Marital and Family Therapy, 14,* 225–236.
Falco, J. (1988). Preventing abuse of drugs, alcohol, and tobacco by adolescents. Working paper for Carnegie Council on Adolescent Development. Washington, DC.
Falicov, C. (1988). *Family transitions: Continuity and charge over the life cycle.* New York: Guilford.
Feldman, S. S., & Elliot, G. R. (1990). *At the threshold: The developing adolescent* (pp. 388–413). Cambridge, MA: Harvard University Press.
Finchman, F. D., & Bradbury, T. N. (1988). The impact of attributions in marriage: Empirical and conceptual foundations. *British Journal of Clinical Psychology, 27,* 77–90.

Fisch, R. (1989). Training in the brief therapy model. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision.* New York: Guilford.
Fishman, H. C. (1988). *Treating troubled adolescents: A family therapy approach.* New York: Basic Books.
Folkman, S., Schaefer, C., & Lazarus, R. (1979). Cognitive processes as mediators of stress and coping. In V. Hamilton & D. M. Warburton (Eds.), *Human stress and cognition: An information-processing approach.* London: Wiley.
Fraser, J. S. (1982). Structural and strategic family therapy: A basis for marriage, or grounds for divorce? *Journal of Marital and Family Therapy, 8,* 13–22.
Freud, A. (1958). Adolescence. *Psychoanalytic Study of the Child, 13,* 255–278.
Friedman, A. S., Utada, A., & Morrissey, M. (1987). Families of adolescent drug abusers are "rigid"" Are these families either "disengaged" or "enmeshed," or both? *Family Process, 26,* 131–148.
Furman, W. (1980). Promoting social development: Developing implications for treatment. In B. Lahey & A. Kazdin (Eds.), *Advances in clinical child psychology* (Vol. 3, pp. 1–40). New York: Plenum.
Glynn, T. J. (1984). Adolescent drug use and the family environment; A review. *Journal of Drug Issues, 2.*
Goldfried, M. R., & Wolfe, B. E. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting & Clinical Psychology, 56,* 448–451.
Greenberg, L. S., & Pinsof, W. M. (1986). Process research: Current trends and future perspectives. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process* (pp. 3–20). New York: Guilford.
Greenberg, L. S., & Safran, J. D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8,* 559–578.
Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change.* New York: Guilford.
Greenberg, M. T., Siegel, J. M., & Leitch, C. J. (1983). The nature and importance of attachment relationships to parents and peers during adolescence. *Journal of Youth & Adolescence, 12,* 373–386.
Grotevant, H. D., & Cooper, C. R. (Eds.) (1983). *Adolescent development in the family.* San Francisco: Jossey-Bass.
Gurman, A. S. (1988). Issues in the specification of family therapy interventions. In L. C. Wynne (Ed.), *The state of the art in family therapy research: Controversies and recommendations.* New York: Family Process Press.
Haley, J. (1973). *Uncommon therapy.* New York: Norton.
Haley, J. (1976). *Problem solving therapy.* San Francisco: Jossey-Bass.
Haley, J. (1980). *Leaving home.* New York: McGraw-Hill.
Hall, G. S. (1904). *Adolescence: Its psychology and relation to psychology, anthropology, sociology, sex, crime, religion, and education.* Englewood Cliffs, NJ: Prentice-Hall.
Hartrup, W. (1979). Two social worlds of childhood. *American Psychologist, 39,* 955–960.
Hauser, S. T., Borman, E. H., Jacobson, A. M., Powers, S. I., & Noam, G. G. (1991). Understanding family context of adolescent coping: A study of parental ego development and adolescent coping strategies. *Journal of Early Adolescence, 1,* 96–124.

Hauser, S. T., & Follansbee, D. (1984). Developing identity: Ego growth and change during adolescence. In H. Fitzgerald, B. Lester, & M. Yogman (Eds.), *Theory and research in behavioral pediatrics.* New York: Plenum.
Hauser, S. T., Houlihan, J., Powers, S. I., Jacobson, A. M., Noam, G. G., Weiss-Perry, B., Follansbee, D., & Book, B. K. (in press). Adolescent ego development within the family: Family styles and family sequences. *International Journal of Behavioral Development.*
Hauser, S. T., Powers, S. I., Noam, G., & Bowlds, M. K. (1987). Family interiors of adolescent ego development trajectories. *Family Perspective, 21,* 263-282.
Hauser, S. T., Powers, S., Noam, G. G., Jacobson, A. M., Weiss, B., & Follansbee, D. J. (1984). Family context of adolescent ego development. *Child Development, 55,* 195-213.
Henggeler, S. W., Rodick, J. D., Bourduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. *Developmental Psychology, 22,* 132-141.
Hill, J. P. (1980). The family. In M. Johnson & K. J. Rehage (Eds.), *Toward adolescence: The middle school years. Part I.* Chicago: University of Chicago Press.
Hill, J. P., & Holmbeck, G. N. (1986). Attachment and autonomy during adolescence. In G. T. Whitehurst (Ed.), *Annals of child development* (Vol. 3, pp. 145-189). Greenwich, CT: JAI Press.
Hoffman, L. (1981). *Foundations of family therapy.* New York: Basic Books.
Institute of Medicine Report. (1989). *Research on children and adolescents with mental, behavioral & developmental disorders.* U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.
Jessor, R., & Jessor, S. L. (1977). The social-psychological framework. In R. Jessor & S. L. Jessor (Eds.), *Problem behavior & psychosocial development: A longitudinal study of youth* (pp. 17-42). New York: Academic Press.
Jurich, A. (1990, July/August). The jujitsu approach: Confronting the belligerent adolescent. *Family Therapy Networker,* 43-45, 47, 64.
Kandel, D. B., Kessler, R. C., & Margulies, R. Z. (1978). Antecedents of adolescent initiation into stages of drug use: A developmental analysis. *Journal of Youth and Adolescence, 7*(1).
Kaslow, F. W. (Ed.). *Voices in family psychology, Volumes I and II.* Newbury Park, CA: Sage.
Kaslow, F. W. (1987). Trends in family psychology. *Journal of Family Psychology, 1,* 77-90.
Kaufman, E. (1985). Family systems and family therapy of substance abuse: An overview of two decades of research and clinical experience. *International Journal of the Addictions, 20,* 697-916.
Kazdin, A. E. (1982). Symptom substitution, generalization, and response covariation: Implications for psychotherapy outcome. *Psychological Bulletin, 91,* 349-365.
Kazdin, A. E. (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin, 102,* 187-203.
Kazdin, A. E. (1989). Developmental psychopathology: Current research, issues and directions. *American Psychologist, 44,* 180-187.
Kazdin, A. E., Bass, D., Ayers, W. A., & Rodgers, A. (1990). Empirical and clinical

focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology, 58,* 729-740.
Kendall, P. C., Lerner, R. M., & Craighead, W. E. (1984). Human Development and Intervention in Childhood Psychopathology. *Child Development, 55,* 71-82.
Koestler, A. (1979). *Janus.* New York: Basic.
Lambert, M. J., & Ogles, B. M. (1988). Treatment manuals: Problems and promise. *Journal of Integrative and Eclectic Psychotherapy, 7,* 187-204.
Larson, R. W. (1983). Adolescents' daily experiences with family and friends: Contrasting opportunity systems. *Journal of Marriage and the Family, 45,* 739-750.
Lazarus, R., Coyne, J., & Folkman, S. (1982). Cognition, emotion, and motivation: The doctoring of Humpty-Dumpty. In R. W. J. Neufeld (Ed.), *Psychological stress and psychopathology.* New York: McGraw Hill.
Lebow, J. L. (1987). Developing a personal integration in family therapy: Principles for model construction and practice. *Journal of Marital and Family Therapy, 13,* 1-14.
Lerner, R. M. (1978). Nature, nurture and dynamic interactionism. *Human Development, 21,* 1-20.
Levine, B. L. (1985). Adolescent substance abuse: Toward an integration family systems and individual adaptation theories. *American Journal of Family Therapy, 13,* 3-16.
Lewis, R. A., Piercy, F. P., Sprenkle, D. H., & Trepper, T. S. (1990). Family-based interventions for helping drug-abusing adolescents. *Journal of Adolescent Research, 50,* 82-95.
Liddle, H. A. (1982). Review of *Foundations of family therapy: A conceptual for systems change. American Journal of Family Therapy, 10,* 76-83.
Liddle, H. A. (Ed.) (1983). *Clinical implications of the family life cycle.* Rockville, MD: Aspen Publications.
Liddle, H. A. (1984). Toward a dialectical-contextual-coevolutionary translation of structural-strategic family therapy. *Journal of Strategic and Systemic Therapies, 4,* 66-79.
Liddle, H. A. (1985). Five factors of failure in structural-strategic family therapy: A contextual construction: In S. Coleman (Ed.), *Failures in family therapy.* New York: Guilford.
Liddle, H. A. (1987a). Family psychology: The journal, the field. *Journal of Family Psychology, 1,*(1), 5-22.
Liddle, H. A. (1987b). Family psychology: Tasks of an emerging (and emerged) discipline. *Journal of Family Psychology, 1,*(2), 149-167.
Liddle, H. A. (1988a). Developmental thinking and the family life cycle: Implications for training family therapists. In C. Falicov (Ed.), *Family transitions.* New York: Guilford.
Liddle, H. A. (1988b). Systemic supervision: Conceptual and pragmatic guidelines. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision.* New York: Guilford.
Liddle, H. A. (1990). What's wrong with family therapy? Presentation at symposium "What's wrong with family therapy?" at the 1990 AAMFT meeting, Washington, DC.
Liddle, H. A. (1991a). The adolescents and families project: Multidimensional family therapy in action. In *ADAMHA monograph from the first national*

conference on the treatment of adolescent drug, alcohol and mental health problems. Washington, DC: United States Public Health Service, Government Printing Office.
Liddle, H. A. (1991b). Engaging the adolescent in family systems therapy. In T. Nelson (Ed.), *Interventions in family therapy.* New York: Haworth.
Liddle, H. A. (1991c). Family therapy training and supervision: A comprehensive review and critique. In A. Gurman & D. Kniskern (Eds.), *Handbook of family therapy* (2nd ed.). New York: Brunner/Mazel.
Liddle, H. A. (1991d). Empirical values and the culture of family therapy. *Journal of Marital and Family Therapy, 17,* 327-348.
Liddle, H. A., Dakof, G., Parker, K., & Diamond, G. (1991, August). *Anatomy of a clinical research project.* Paper presented at the American Psychological Association Meeting, San Francisco.
Liddle, H. A., & Schmidt, S. (1991). *Family therapy with drug abusing adolescents: The state of the art.* Invited technical report prepared for the NIDA meeting on the five year plan for the Treatment Research Branch, Bethesda, Maryland, February 7-8.
Liddle, H. A., Schmidt, S., & Ettinger, D. (in press). Adolescent development research: Guidelines for clinicians. *Journal of Marital and Family Therapy.*
Loeber, R. (1985). The patterns and development of antisocial child behavior. *Annals of Child Development, 2,* 77-116.
Madanes, C. (1981). *Strategic family therapy.* San Francisco: Jossey-Bass.
Madanes, C. (1985). *Behind the one way mirror.* San Francisco: Jossey-Bass.
Maddahian, E., Newcomb, M. D., & Bentler, P. M. (1986). Adolescents' substance use: Impact of ethnicity, income, and availability. In *Alcohol and substance abuse in women and children.* New York: Haworth Press.
Magnusson, D. (1988). *Individual development from an interactional perspective: A longitudinal study.* Hillsdale, NJ: Lawrence Erlbaum.
Mahoney, M. J. (1984). Integrating cognition, affect, and action: A comment. *Cognitive therapy and research, 8,* 585-589.
Mahrer, A. R. (1988a). Discovery oriented psychotherapy research: Rationale, aims and methods. *American Psychologist, 43,* 694-702.
Mahrer, A. R. (1988b). Research and clinical applications of "good moments" in psychotherapy. *Journal of Integrative Eclectic Psychotherapy, 7,* 81-93.
Miller, G. E., & Prinz, R. J. (1991). Enhancement of social learning family interventions for childhood conduct disorders. *Psychological Bulletin, 108,* 291-307.
Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.
Minuchin, S., & Fishman, H. C. (1981). *Family therapy technique.* Cambridge, MA: Harvard University Press.
Nadelman, E. A. (1989). Drug prohibition in the United States: Costs, consequences, and alternatives. *Science, 245,* 939-947.
National Institute on Drug Abuse (Treatment Research Branch). (1991). Meeting on the five year plan for the Treatment Research Branch of NIDA, Bethesda, Maryland, February 7-8.
Newcomb, M. D., & Bentler, P. M. (1988). Impact of adolescent drug use and social support on problems of young adults: A longitudinal study. *Journal of Abnormal Psychology, 97,* 64-75.
Newcomb, M. D., & Harlow, L. L. (1986). Life events and substance use among adolescents: Mediating effects of perceived loss of control and meaninglessness in life. *Journal of Personality & Social Psychology, 51,* 564-577.

Newcomb, M. D., Maddahian, E., & Bentler, P. M. (1986). Risk factors for drug use among adolescents: Concurrent & Longitudinal analysis. *American Journal of Public Health, 76,* 525-531.
Nichols, M. (1987). *The self in the system.* New York: Brunner/Mazel.
Offer, D., Ostrov, E., & Howard, K. I. (1981). The mental health professional's concept of the normal adolescent. *Archives of General Psychiatry, 38,* 149-152.
Pandina, R. J., & Schuele, J. A. (1983). Psychosocial correlates of alcohol and drug use of adolescent students and adolescents in treatment. *Journal of Studies on Alcohol, 44,* 950-973.
Patterson, G. R., Dishion, T. J., & Bank, L. (in press). Family interaction: A process model of deviancy training. In L. Eron (Ed.), special edition of *Aggressive Behavior,* in press.
Peele, S. (1986a). The "cure' for adolescent drug abuse: Worse than the problem. *Journal of Counseling and Development, 65,* 23-24.
Peele, S. (1986b). The dominance of the disease theory in American ideas about and treatment of alcoholism. *American Psychology,* 323.
Peele, S. (1986c). The implications and limitations of genetic models of alcoholism and other addictions. *Journal of Studies on Alcohol, 76,* 63-73.
Pinsof, W. M. (1988). A conceptual framework and methodological criteria for family therapy research. *Journal of Consulting and Clinical Psychology, 57,* 1-7.
Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance; Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12,* 137-151.
Pittman, F. S. (1987). *Turning points.* New York: Norton.
Reilly, D. M. (1975). Family factors in the etiology and treatment of youthful drug abuse. *Family Therapy, 2,* 149-171.
Reilly, D. M. (1979). Drug-abusing families: Intrafamilial dynamics and brief triphasic treatment. In E. Kaufman & P. N. Kaufmann (Eds.), *Family therapy of drug and alcohol abuse.* New York: Gardner Press.
Reilly, D. M. (1984). Family therapy with adolescent drug abusers and their families: Defying gravity and achieving escape velocity. *Journal of Drug Issues, 14,* 381-390.
Rieder, C., & Cicchetti, D. (1990). Organizational perspective on cognitive control functioning and cognitive-affective balance in maltreated children. *Developmental Psychology, 25,* 382-393.
Robin, A. L., & Foster, S. L. (1989). *Negotiating parent adolescent conflict: A behavioral-family systems approach.* New York: Guilford.
Rutter, M., & Sroufe, L. A. (1984). The domain of developmental psychopathology. *Child Development, 55,* 17-29.
Ryan, R. M., & Lynch, J. H. (1989). Emotional autonomy versus detachment: Revising the vicissitudes of adolescence and young adulthood. *Child Development, 60,* 340-356.
Safran, J. D. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review, 10,* 87-105.
Safran, J. D. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review, 10,* 107-121.
Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27,* 154-165.

Schwartz, R. C. (1987). Our multiple selves. *The Family Therapy Networker, 11,* 25–31, 80–83.
Schwartz, R. C. (1988). Know thy selves. *The Family Therapy Networker, 12,* 21–29.
Shantz, C. V. (1983). Social cognition. In J. H. Flavell & E. M. Markman (Eds.), *Handbook of child psychology, Vol. 3: Cognitive development* (pp. 495–555). New York: Wiley.
Shirk, S. R. (Ed.) (1988). *Cognitive development and child psychotherapy.* New York: Plenum.
Siegel, I. (1982). *Parental belief systems.* Hillsdale, NJ: Lawrence Erlbaum.
Solomon, M. (1973). A developmental conceptual premise for family therapy. *Family Process, 12,* 179–188.
Stanton, M. D. (1981). An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy, 7,* 427–439.
Stanton, M. D. (1984). Fusion, compression, diversion, and the workings of paradox: A theory of therapeutic/systemic change. *Family Process, 23,* 135–168.
Stanton, M. D. (1988). The lobster quadrille: Issues and dilemmas for family therapy research. In L. C. Wynne (Ed.), *The state of the art in family therapy research: controversies and recommendations* (pp. 7–31). New York: Family Process Press.
Stanton, M. D. (1991). *Outcome research on family treatment for drug abuse: Implications for practitioners.* Presentation at the NIDA Conference on Drug Abuse Research and Practice. Washington, DC, January 12–15.
Stanton, M. D., Todd, T. C., and associates. (1982). *The family therapy of drug abuse and addiction.* New York: Guilford.
Steinberg, L. (1990). Autonomy, conflict, and harmony in the family relationship. In S. S. Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (pp. 255–276). Cambridge, MA: Harvard University Press.
Steinberg, L., & Silverberg, S. (1986). The vicissitudes of autonomy in early adolescence. *Child Development, 57,* 841–851.
Stratton, P. (1988). Spirals & circles: Potential contributions of developmental psychology to family therapy. *Journal of family therapy, 10,* 207–231.
Szapocznik, J., Kurtines, W., Santisteban, D. A., & Rio, A. T. (1990). Interplay of advances between theory, research, and applications in treatment interventions aimed at behavior problem children and adolescents. *Journal of Consulting and Clinical Psychology, 58,* 696–703.
Szapocznik, J., Perez-Vidal, A., Brickman, A. L., et al. (1988). Engaging adolescent drug abusers and their families in treatment a strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56,* 552–557.
Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santiseban, D., Hervis, O., & Kurtines, W. M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56,* 552–557.
Tobler, N. (1986). Meta-analysis of 143 adolescent drug prevention programs. *Journal of Drug Issues, 16,* 537–567.
Todd, T. C. (1986). Structural-strategic marital therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 71–105). New York: Guilford Press.
Todd, T. C. (1990, November). Presentation at ADAMHA Conference on Mental Health and Drug Abuse Problems of Adolescents. Washington, DC.

Todd, T. C., & Selekman, M. D. (1990a). Beyond structural-strategic family therapy. In T. Todd & M. Selekman (Eds.), *Family therapy with adolescent substance abusers.* Boston: Allyn and Bacon.
Todd, T. C., & Selekman, M. (1990b). Principles of family therapy for adolescent substance abuse. In P. H. Tolan (Ed.), *Multisystemic structural-strategic interventions for child and adolescent behavior problems* (pp. 49–70. New York: Haworth.
Tolan, P. H. (1990). Introduction: Treating behavioral problems from a multi-level structural-strategic approach. *Journal of Psychotherapy and the Family, 6,* 1–8.
Tramontana, M. G. (1980). Critical review of research on psychotherapy outcome with adolescents: 1967–1987. *Psychological Bulletin, 88,* 429–450.
Volk, R. J., Edwards, D. W., Lewis, R. A., & Sprenkle, D. H. (1989). Family systems of adolescent substance abusers. *Family Relations, 38,* 266–272.
Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration.* New York: Basic Books.
Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55,* 542–549.
Wills, T. A. (1990). Social support and the family. In E. A. Blechman (Ed.), *Emotions and the family: For better or worse.* Hillsdale, NJ: Erlbaum.
Wills, T. A., & Vaughn, R. (1989). Social support and smoking in early adolescence. *Journal of Behavioral Medicine, 12,* 321–339.